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MARGARET M. HECKLER, TO BE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES—ADDITIONAL CONSIDERATION

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

ON

ADDITIONAL CONSIDERATION OF MARGARET M. HECKLER, OF MASSACHUSETTS, TO BE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

MARCH 3, 1983

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MARGARET M. HECKLER, TO BE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES—ADDITIONAL CONSIDERATION

WEDNESDAY, MARCH 2, 1983

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 3 p.m., in room 4252, Dirksen Senate Office Building, Senator Orrin Hatch (chairman of the committee) presiding.

Present: Senators Hatch, Stafford, Quayle, Denton, Weicker, Humphrey, Kennedy, Randolph, Pell, and Riegle.

OPENING STATEMENT OF SENATOR HATCH

The CHAIRMAN. Good afternoon, Mrs. Heckler. It is a pleasure to have you here today.

We are here to consider the nomination of Mrs. Margaret Heckler to be Secretary of the Department of Health and Human Services. I know that Mrs. Heckler commands the highest respect of this entire committee, and I have no doubt she will be confirmed by the Senate. I am glad that we have this opportunity to formally welcome her to our team.

We will be fortunate to have as head of the Department with the third largest budget in the world someone with Margaret Heckler's experience and sensitivity in many health-related areas. After eight terms in the House of Representatives, Mrs. Heckler is equipped with exceptional prowess in the workings of our Government. She has served on the House Committee on Agriculture, the House Committee on Veterans' Affairs, and the House Committee on Science and Technology. She is a supporter of home health care, and one of the earliest House cosponsors of my home health care legislation which was approved by this committee. She has worked on behalf of the veterans in establishing centers on aging in 15 hospitals. She was a cosponsor of the Arthritis Institute legislation and served on the board of the Food Safety Council. In short, Mrs. Heckler remains fresh in the memories of her former legislative colleagues as one of the doers in Congress.

Mrs. Heckler and I share many of the same concerns, as do other members of this committee, for health research, revision of Federal food safety laws, the Arthritis Institute, and the Ashbrook amendment.

I look forward to hearing Mrs. Heckler's statement and her answers to our questions.

On behalf of the Committee on Labor and Human Resources, I extend my vote of confidence to Mrs. Margaret Heckler. She will manage the Department of Health and Human Services with the skill and good judgment for which she is known and revered as a former Member of Congress.

We are happy to welcome you here.

You have the distinguished senior Senator from the State of Massachusetts, who is the ranking minority member on this committee, here with you.

We are grateful to have you with her, Ted.

Senator KENNEDY. Thank you very much, Mr. Chairman and members of the committee.

This is becoming somewhat of a routine, presenting Margaret Heckler to a Senate committee. When I had the chance to do so over at the Senate Finance Committee I asked that the Finance Committee treat her as expeditiously as the Commerce Committee did Elizabeth Dole.

Let me say, Mr. Chairman, that I welcome the chance to introduce a colleague to this committee. I think Massachusetts has had a long and proud bipartisan tradition of men and women who have served not only in the Congress of the United States, but also served in important positions in different administrations. We are extremely proud of that tradition.

Margaret Heckler served, as you pointed out, for 16 years in the Congress of the United States. There were areas in which we agreed and areas in which we differed, but there was never any doubt in my mind, or in the minds of her Massachusetts constitients whom she represented so well, about her basic integrity, compassion, and sense of decency. She may have lost a congressional district, but in a very real sense she has gained a much larger constituency, one that needs the kind of concern that she has demonstrated over the years that she has served in the Congress.

These are the very young, the children in our society, the students, the sick in our society, the handicapped, the elderly in our society—all those who find themselves in such difficult straits, particularly at the present time in our Nation.

Therefore, her position is really of enormous importance. I do not think there is an agency now which is of greater importance to the quality of life of the American people than the one I am confident that she will lead.

I welcome the chance to present Margaret Heckler to this committee. She has served well in the Congress of the United States. I know that she will serve the President and the American people well.

I think that we are particularly fortunate today to have—I will let her introduce her daughters but I will usurp the opportunity of introducing her cousins who came all the way from Ireland to this particular occasion: Teresa Sheehy from Limerick, Ireland, and Mary Buckley from County Carey. They add a particular sense of heritage to this hearing. [Applause.]

The CHAIRMAN. Can we have you rise so we all will know who you are?

It is great to have you here. [Applause.]

Senator Kennedy, thank you for that eloquent introduction of Mrs. Heckler to our committee.

I wonder if any other members of this committee would care to make any comments.

Senator Stafford?

Senator **Stafford**. Only very briefly, Mr. Chairman.

I have known Mrs. Heckler for some time—I am not going to say how long, but we served together in the U.S. House. I was very much impressed with her there and her experience in that body.

The **Chairman**. Thank you.

Senator Randolph?

Senator **Randolph**. Thank you very much, Mr. Chairman.

I join with you and other members of this committee in a very warm and understandable welcome because of Mrs. Heckler's record. I assure you of my support, and that is not a statement that is made off the cuff; it is something that I have studied very carefully in reference to your service in the House of Representatives. I will, of course, support your nomination in this committee and will support it in the Senate itself. I am sure that we will report your nomination as Secretary of the Department of Health and Human Services to the Senate.

This is the committee, Mrs. Heckler, as you know, that has given much attention to the subject matter that you will be attempting, and I believe successfully attempting, to cope with. From this committee came the programs such as the aid to those who suffered from pneumoconiosis, black lung. It came from this committee. As you know, the legislation on occupational health and safety came from this committee in 1973.

From these subjects, you recognize the intense interest that we have in matters that, in part, will be within your jurisdiction. You have a major responsibility to oversee and administer health and welfare programs of crucial importance to the people of every State of the Union. They need sources of health services at a time now of economic crisis, crisis that is not going to go away very quickly.

I say to you, Mr. Chairman, that in the State of West Virginia we have an unemployment rate at the present time of almost 19 percent. That is the highest of any State in the Union. Therefore, we understand the unemployment of people and the problems that come from unemployed workers, and of course the impact on their families.

Chairman **Hatch**. If I may be indulged, I would ask one or two questions at the present time.

The **Chairman**. Could we wait until everybody makes their statements?

Senator **Randolph**. I thank you very much.

The **Chairman**. Thank you, Senator Randolph.

Senator Nickles?

Senator **Nickles**. Thank you, Mr. Chairman.

Mrs. Heckler, welcome to the committee. We look forward to working with you in the years to come.

I compliment you, too, on your courage. To tackle the administration of an agency as large as the Department of Health and Human Services with a budget of $274 billion in 1984, up by about

$100 billion in the past 4 years, is a tremendous responsibility. It certainly is a challenge for you and a challenge for any person. I think you are to be complimented for your courage and conviction.

I look forward to working with you because, as Senator Randolph said, a lot of the administrative part of the budget does deal directly with this committee. I think you will find that most members of this committee will work with you in a bipartisan fashion in whatever way we can to help administer those funds and see if they can be spent in a very wise and prudent manner.

Thank you, Mr. Chairman.

The **CHAIRMAN**. Thank you, Senator Nickles.

Senator Pell?

Senator **PELL**. Thank you, Mr. Chairman.

As a neighbor and a friend for many years, I am delighted to welcome Mrs. Heckler here. I look forward to supporting her, working with her.

She has the quality of compassion and interest in people. I guess I could cite a particular instance of that that is in my mind. About 6 years ago she was on that Friday plane that people take up to New England to her area. She was sitting next to a young woman. She had no idea who she was. She talked to her in a very kind and warm way, and most of us would much prefer to have been sleeping or reading. Later on it developed that young woman was my daughter. When they parted my daughter had not let on who it was, and Margaret had been kind to her just out of the goodness of her heart. I just wanted to say so publicly. [Laughter.]

The **CHAIRMAN**. That's great testimony.

Senator Denton?

Senator **DENTON**. I just want to join in the chorus of welcoming Mrs. Heckler. Since I cannot claim that Lloyd George knew my father, I can say that I did serve with you on the Veterans Affairs House-Senate Conference. I was edified by your knowledge and realism and compassion there. I am edified by what I know of your career. I feel very confident that after the questioning I will be as enthusiastic about your nomination as before.

The **CHAIRMAN**. Senator Weicker?

Senator **WEICKER**. I have no opening statement.

The **CHAIRMAN**. Fine.

Mrs. Heckler, would you care to give your statement at this time?

STATEMENT OF MARGARET M. HECKLER, SECRETARY-DESIGNATE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mrs. **HECKLER**. Mr. Chairman and members of the committee, I would like to state that I have my daughters, Belinda and Allison Heckler, here with me.

The **CHAIRMAN**. Why don't we have your daughters rise?

Mrs. **HECKLER**. We have an international contingent which Senator Kennedy already presented. [Applause.]

The **CHAIRMAN**. We are very happy to have your two daughters and your relatives from Ireland. This is a very appropriate committee to be before because we have so many Irish Senators on this committee, not the least of whom sits to my right as you are looking at us. We also have some Irish tempers on this committee from time to time. [Laughter.]

Go ahead, Mrs. Heckler.

Mrs. HECKLER. I can understand why Senator Kennedy introduced my Irish cousins. He has a tremendous constituency in Ireland. The name is a household word, but then so is President Reagan's. [Laughter and applause.]

However, I want to say to my colleague from Massachusetts how genuinely grateful I am for his presentation, for his very eloquent remarks, and for his graciousness in appearing before the Senate Finance Committee—and I have to say that Senator Dole was as kind to me as he was to Mrs. Dole before that hearing, in view of the fact that they reported out my confirmation this morning.

The fact is that I do appreciate all the thoughtfulness that my colleague has extended to me.

I want to say to my other colleagues, former colleagues in the Congress and future colleagues in a new adventure with me, that your auspicious and heart-warming words are a fitting introduction to what will be a very difficult assignment for me, one in which I can only succeed with the advice and consent, goodwill, and cooperation of the Congress. I am very heartened by your warmth today.

Mr. Chairman, I would like to say that I understand this committee well; and I feel that just as I accepted the President's challenge to serve as his Secretary of Health and Human Service, you have sought to serve the same constituency by serving on this committee. I think that we are, then, in a sense partners in the compassion of Government toward those most in need.

I would hope that, if confirmed as the Secretary of Health and Human Services, I would be a catalyst for that compassion and that caring in this country. I reiterate this wish, because I know it is also your wish in the role you play, since you serve the same groups, the same constituency.

The commitment to health and human services certainly is the hallmark of all your own legislative service.

Let me say that I will be your active partner in this process. With my experience from having served in the legislative branch of Government for 16 years, and hopefully in the next few days in the executive branch, I will come to grips with the momentous challenges which face our country on the many fronts in which the Department of Health and Human Services directly touches the lives of American people. I am both humbled and challenged by the opportunity.

It seems to me that, as has been mentioned by others, the Health and Human Services Department is a post which is awesome, not only because of its size, but also because of its mark on the lives of individuals in America. Certainly, its budget is awesome, exceeded only by the budgets of the United States itself in total Federal outlays and that of the Soviet Union. The Department of Health and Human Services employs 142,000 people, who in turn directly serve more than 50 million of our fellow citizens.

I have said before, on the way to the last election, I lost 145,000 constituents, and now I have gained 142,000 employees. It is an interesting trade.

Until now, my public service has centered on Capitol Hill. As a Member of Congress, I worked with many of you to set policy objectives by writing into law answers to pressing national and international problems.

If you and your colleagues confirm my nomination, the focus and thrust of my activity will change: I will be implementing the will of Congress and the President by making sure that the laws actually work for the American people, and work honestly, efficiently, and imaginatively.

Finally, Mr. Chairman, before I answer the committee's questions, I would like to comment on a specific matter which impacts on the conscience and caring of all Americans: The double goal of protecting human life and preserving the civil rights of handicapped persons.

As you know with the help of some of us in this room, Congress in 1973, passed the Rehabilitation Act. Section 504 of that act declares that:

> No otherwise qualified handicapped individual * * * shall, solely by reason of his (or her) handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

In enacting that statute, Congress broke new, and I believe necessary, ground to improve and enrich the lives of handicapped Americans.

Last year, Mr. Chairman, millions of Americans were stunned, shocked, and angered when the death of a handicapped newborn infant in Bloomington, Ind., brought to public attention the tragedy of that and other cases in which nutrition or medical care was deliberately denied to handicapped individuals.

The President responded swiftly to the tragic tidings from Bloomington. He directed the Health and Human Services Department to make clear to every health care facility in the United States of America that section 504 of the Rehabilitation Act of 1973 protects all handicapped persons, including infants. The Health and Human Services Office for Civil Rights followed up on the President's directions directed on May 18, 1982, in a written notice which was sent to hospitals nationwide.

Today, Mr. Chairman, the Department of Health and Human Services has taken a further step to implement the President's direction on handicapped infants: Health and Human Services will publish in the Federal Register interim final regulations requiring that each and every recipient of Federal funds who provides covered health care services post and keep posted in a conspicuous place—in delivery, pediatric, and maternity wards, along with nurseries, including intensive care nurseries—a notice stating that, Discriminatory failure to feed and care for handicapped infants in this facility is prohibited by Federal law."

The notice will put the public and the medical profession on notice that anyone who has knowledge that a handicapped infant is being discriminatorily denied nutrition or medical care can and should immediately contact a toll-free, 24-hour Health and Human Services hotline or, in the alternative, the State child protective agency to report the alleged violation.

The Department's action is prompted by the accumulation of additional evidence that handicapped children's lives are in jeopardy, that some have indeed been lost by decisions to withhold food or services.

Mr. Chairman, we are a nation which cherishes diversity and pluralism, but there is among all of us a universal respect for the first word in that trilogy which the Declaration of Independence has enshrined in our hearts, "We hold these truths to be self-evident, that all men are * * * endowed by their Creator with certain inalienable rights * * * life, liberty, and the pursuit of happiness."

The Department's action today, undertaken to honor those words and the implementing language of section 504 of the Rehabilitation Act, follows the same thrust. I endorse the President's initiative on this matter and the followup action which my hopefully soon-to-be, colleagues at the Department of Health and Human Services have taken to protect what all of us agree is sacred: that is, human life.

And now, Mr. Chairman, I would be happy to respond to any comments or questions which you and the members of the committee may have.

The CHAIRMAN. Thank you, Mrs. Heckler. We appreciate your excellent opening statement.

I understand that Mrs. Heckler has to leave no later than 5 o'clock. Therefore, we will abide by the 10-minute rule for all Senators and try to get as many questions in as we can by that time.

In fact, Senator Weicker has to catch a plane. Therefore, I will ask a few questions, and then I will yield to him so that he can ask a few before he leaves, if that is all right with the rest of our colleagues. Then we will proceed in regular order.

Mrs. Heckler, former Secretary Schweiker has been a champion of preventive medicine and health promotion. Shortly before leaving office, he announced a major new campaign called "stay alive." That encompassed Federal, State, and local efforts to promote healthy lifestyles. Will this program remain a priority with you and with HHS, and will you be submitting legislative proposals to implement this program?

Mrs. HECKLER. The program will remain a definite priority of the Department and a priority of mine. I applaud Secretary Schweiker's initiative in this area. I personally intend to follow the plan that he has already set into motion in the Department. It is being carried out at the State and local levels across the country.

As to legislative initiatives, I would have to say that those must await my further review. I am thoroughly in support of the program, but not convinced at this point that a legislative initiative is necessarily required in order to carry out the full promise of his leadership in this area.

The CHAIRMAN. Thank you.

Will you continue to support the consolidation of family planning programs under the Deputy Assistant Secretary for Population Affairs at the Department of Health and Human Services?

Mrs. HECKLER. This consolidation has already taken effect, and I believe that it will provide a better management opportunity for the required services. I have met with the Deputy Assistant Secretary for Population Affairs, who will be in charge of and oversee the title X function as well. In the brief time that I had with her, I became convinced that she will carry out those responsibilities, with a conscientious sense of mission toward the family planning function, which is a very important part of this new consolidation.

The **Chairman**. When I met with you earlier this month I expressed my commitment to improving home health care services for elderly citizens. Now this population is growing rapidly, but resources to provide for home health care, of course, are limited. I am convinced that both the quality and the economy of such care will be significantly improved if basic services can be provided in their own homes and communities. Home health care increases longevity and patient satisfaction, and this has been well documented. What is your position regarding home health care?

Then I would like to ask your position with regard to home health care legislative initiatives.

Mrs. **Heckler**. Mr. Chairman, I am very supportive of home health care. I have looked upon it as an alternative to institutionalization. In that sense, I feel that it not only can be a very, very understanding and sympathetic means of treating our older citizens, but it can also be a cost-effective strategy for the Government.

At the present time, there are demonstration projects underway in the Department, challenging projects undertaking to assess the value of new home health care initiatives. As I await the final report on their experience in the field, I do so with the expectation that these services will prove as valuable as I have always believed them to be in the past.

The **Chairman**. Would you consider developing legislative initiatives to create incentives that will encourage health care providers to shorten patient hospital stays when appropriate by improving access to basic health care in their homes?

Mrs. **Heckler**. Let me say that I wish to respond conceptually. I am certainly very supportive of home health care. In terms of a legislative initiative, I would like to see the specifics of a proposal before commenting on it. In general, I support home health care as a means of caring for our older citizens. From my own, prior experience in Congress, it seems to be not only warranted, but also a desirable goal for the country.

The **Chairman**. Mrs. Heckler, I would like to alert you to an issue of great interest to me. As you probably know, over the last several years there has been considerable public debate and discussion about our food safety laws. I plan to actively continue these discussions because I think they need to take place during the 98th Congress, and we will be asking you for specific recommendations for revisions of the Federal Food, Drug and Cosmetic Act at hearings this spring.

Is it too early for you to have any thoughts with regard to what you might recommend for revising the Federal Food, Drug, and Cosmetic Act regarding this Nation's food safety policies?

Mrs. **Heckler**. Obviously, I think the review is warranted and justified by the facts. I would also like to note that there is a review being undertaken at the moment by a working group composed of the Department and other agencies. They are presently working on developing recommendations for the components of a policy modification. Before I make a judgment on which alternative, if any, I will support, I would like to see the recommendations of this working group. I would like to say that I think the issue is timely and of major concern, and I certainly will be open to the recommendations and look forward to assessing them.

The **Chairman**. Last year I introduced the Comprehensive Smoking Prevention Education Act, S. 1929, which would require new and stronger warning labels specifying the health consequences of smoking be rotated on cigarette packages. Now the administration did not support this legislation, although it reportedly did support a stronger warning label.

What is your position on multiple warning label legislative approaches as a public health effort in smoking prevention? Do you know if you will be submitting any legislative initiatives with regard to that?

Mrs. **Heckler**. I feel that the warning label is a very important part of health care in America today, and I think that a strong, effective label is an essential part of the education process in which the Government has been engaged in the past. It has to be a continuing subject of concern.

As to support for specific legislative approaches, I would have to say that the Department plans no legislative initiative, and I would withhold comment pending the actual introduction of a new proposal.

The concept of a strong warning label is one that I heartily endorse, however.

The **Chairman**. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has now completed its work, having covered all subject areas assigned to it by law. Now I know that during the Commission's tenure the Department continued its own activities in this area.

Could you describe some of these activities and discuss your own view on what the Department of Health and Human Services should be doing to address ethical problems in medicine and biomedical research?

Mrs. **Heckler**. The actual problems in biomedical research and medicine, of course, are of such scope and magnitude that an ongoing consideration, indeed, has been a fact of life at the Department for several years now. I think this must continue.

My view is that the Commission has served a very useful purpose and that, as a result of that, the issue of the rights of human subjects and the protection of those rights has now become the focus of a government-wide working group composed of representatives of 22 agencies and chaired by the very able Assistant Secretary for Health Dr. Edward Brandt. I think that enormous good has been achieved. I see this as an issue that has to be, and will be, very conscientiously pursued by the Department and by the Government.

The **Chairman**. Mrs. Heckler, on January 4 President Reagan signed Public Law 97-414, the Orphan Drug Act, into law. This law contains a section 7 that requires Health and Human Services to develop radioepidemiological tables that will show the probability that people who suffer from cancer developed their disease as a result of their prior exposure to given doses of ionizing radiation.

Health and Human Services has been given 1 year to complete this project, which is 6 months longer than Assistant Secretary Brandt said would be needed when he testified before this committee last March. Still now there are only 10 months remaining before the report is due. I would like to know if the Department has made final plans for the development of these tables and, if not, I would like to know when these plans will be completed, if you know.

Mrs. HECKLER. The Department is in the process of making final plans.

The CHAIRMAN. They are in the process?

Mrs. HECKLER. Yes, they are.

The CHAIRMAN. Do you feel that they will meet the time constraints that we have in the bill?

Mrs. HECKLER. I do.

The CHAIRMAN. The Omnibus Budget Reconciliation Act of 1981 mandates changes in payments for end-stage renal disease. Could you tell me when the Department expects to have these regulations ready for publication, if you know?

Mrs. HECKLER. These regulations are at a very final stage at the Department at this time.

The CHAIRMAN. I understand that the National Institute on Alcoholism and Alcohol Abuse has been without a Director for some time. Do you expect to have a Director appointed soon? Have you given any consideration to that?

Mrs. HECKLER. I am sorry, Mr. Chairman, I really have not addressed that problem. I would be glad to respond to you, but, among the many issues, concerns, programs, and policies of the Department, that just simply has not come to my attention at this point.

The CHAIRMAN. Without objection, then, we will turn to Senator Weicker, who has to catch a plane.

Senator WEICKER. Mr. Chairman, thank you very much. I also thank my other colleagues, including Senator Kennedy.

First of all, let me state at the outset, so that there will not be any misconception, I intend to vote for your confirmation. I think you will make a fine Secretary.

Having said that, I must confess that I find the words in the statement relative to this action of the administration to be very surprising in light of their actions over the past 2 years.

When I read statements about the "double goal of protecting human life and preserving the civil rights of handicapped persons," when I read statements saying, "Protects all handicapped persons, including infants." When I see, "Is undertaken to honor those words and the implementing language of section 504," I have to ask myself whether or not this is the same administration that tried to gut Public Law 94-142, which is what protects the handicapped and retarded. I have to ask myself whether this is the administration that at the present time is trying to change section 504, and I have to ask myself how that equates with the proposed 33-percent cut in funding for the retarded, the disabled, and the handicapped which has taken place over the past 2 years.

I think that the Bloomington case is certainly one that is spectacular in nature. It catches the eye. I am certainly glad that the administration has taken steps to ensure that that will not happen again. However, I would like to know basically three things:

Very briefly, whether or not you stand by section 504 and Public Law 94-142 as written, as on the books right now; No. 2, whether or not you will support efforts to assure that adequate funding is there for retarded children. It is not just a question of living and breathing, but whether or not they are going to have any chance, and that chance has been severely cut back by lack of funds afforded to them in the past 2 years.

Mrs. HECKLER. Senator, no one can really assess the issue of the handicapped or the disabled with the degree of understanding and compassion that the situation requires. I am constantly being educated on the subject.

I want to say that I do support, and I know that the President does, section 504 in the context of the statement that I made this morning, and I think this is very important in terms of recognizing the rights of the handicapped and the protection of the handicapped.

I feel, indeed, that the issues do involve funding questions and that there will be areas of disagreement in which there will be a consensus developed with the Department, I am sure.

I am told at this stage, having been presented with a budget, the explanation of the budget figures includes the analysis of funding for the developmental disabilities areas, which is designed to deal with bureaucratic and management cutbacks, not services to the handicapped. This is the explanation for the funding level that I received at the Department.

Senator WEICKER. Do you believe that explanation?

Mrs. HECKLER. At this point I am listening to my advisors and I am, of course——

Senator WEICKER. Let me assure you, Madam Secretary, that it is not just administrative costs that were whittled back. It was the services rendered to the retarded and the disabled. Just go out there and ask that community. I will not get into a debate here. That is not the purpose of this. Rather, I look forward to working with you to make sure this does not happen any more than it already has happened. Indeed, if we can go ahead and turn it around, that is even better.

Again, I have to repeat my question which was not answered: Do you stand for section 504 and Public Law 94-142 as written on the books?

Mrs. HECKLER. Senator, I certainly stand for the concepts they express. In terms of an absolute, ironclad commitment to every last comma and word, I cannot make that kind of a commitment at this time, but I do stand for compassion and concern and protection of the civil rights of the handicapped, and I am most familiar with that issue.

I want to say that I personally feel very strongly about honoring that. The type of commitment that you wish potentially embraces areas that I have not yet considered, and I certainly would want time to look at those areas.

Senator WEICKER. At the time of the proposed changes to Public Law 94-142 you were still in the Congress. Did you support those changes or not?

Mrs. HECKLER. Let me just say that I am not aware of any changes that have been proposed this year in either of those laws.

Senator WEICKER. I am talking about when you served in the last Congress, which is when the changes were proposed. Did you support them or not?

Mrs. HECKLER. My congressional record, of course, is a different issue, but I will say that the issue before us today is not what or my feelings were. My feelings were certainly supportive of the handicapped, and they still are. In terms of initiatives this year, whether you know of something that I do not, I do not know. I know of no desire by the administration to water down either of the statutes that you are suggesting. Possibly you are aware of something else.

Senator WEICKER. No. We are all aware in the Congress of what went on, and so are you, and I wish you the——

Mrs. HECKLER. Two years ago, yes.

Senator WEICKER. I wish you the best of luck. Don't let them bury you over there in that administration. [Laughter.]

The CHAIRMAN. As always, Senator Weicker adds a lot to any committee meeting. [Laughter.]

I agree with Senator Weicker—we need to stand up for the handicapped and to make sure those programs are solid, and I am sure you are committed to that.

Senator Kennedy?

Senator KENNEDY. Thank you very much, Mr. Chairman.

Mrs. Heckler—Madam Nominee, I guess would be appropriate to call you—you have not been involved in the formulation of the administration's budget figures.

Mrs. HECKLER. Not at all.

Senator KENNEDY.We must recognize that at the outset, although I think that many of us are enormously troubled by the administration's proposals in a number of different areas. The administration had talked about a freeze in domestic programs, and yet we have seen significant reductions in a wide range of different programs that reach out to the neediest people in our society. Hopefully, maybe you will have time to get into them. Perhaps we can inquire of you in written form.

One of the areas of greatest concern to people not only in Massachusetts but around the country is the serious problem associated with increased cost of health care. This has been an area which I have been interested in over a number of years. I know many other members of this committee have been interested, as well.

Still, we have not, either as a Congress, nor has this administration or previous administrations, really developed adequate programs to address the enormous escalation of health care costs, which is virtually three times above the rate of inflation at the present time.

With the failure of those of us in the legislative branch and the executive branch has meant increasing hardship to millions of elderly people specifically and millions of other people across this Nation.

We have seen the administration's proposals with regard to medicare, which will increase their copayments, increase their premiums, increase their payments on hospitalization. The total cost of that will be about $5 billion for the elderly people in this country over the next 5 years.

People over 65 years of age spend up to 20 percent of their income on health care costs. Still, we have not had a satisfactory response from the administration nor from the Congress.

We did see some changes in medicare in the last Congress, but basically that was a question of cost shifting. For those hospitals that had a patient load that had greater financial resources, they were able to buck it to middle income families and to those with more extensive insurance coverage.

Now we know that out of pocket there is going to be significant increase for people who have the greatest needs of our health care system.

What I would ask you is that you work closely with us on this committee and other committees in trying to fashion and shape a meaningful program. The previous administration proposed a cost containment program. Over the period when that issue was before the Congress, the increase in hospitalization was virtually the rate of inflation. Since the Congress rejected the legislation, we have seen the significant increase.

I do not know whether you have any comments that you would like to make about how we can deal with the cost of containment. Rather than going into it at length in terms of the administration's program, in terms of competition—even the proponents of it say it will take 5 to 7 to 10 years before it even goes into effect—maybe you would like to make a comment. But what I am most interested in is some assurance by you that you will work with us on this committee in trying to develop a realistic program.

I have every intention of introducing legislation in March on it, but I would hope we could get, one, your willingness to work with us who are interested in it and, two, if you have any comments that you would like to make on the whole issue of effective cost containment, I would be interested.

Mrs. **Heckler**. Senator, I think that you are quite correct in saying that the Congress and the executive branch for several years, even a decade or more, have not dealt with the escalation of health care costs. So, this has been a continuing and pervasive public policy problem and, of course, a financial problem, for America.

The fact is that this year we do have an initiative in the prospective payment proposal the administration has suggested, an initiative which, I think can begin to provide an incentive for cost cutting, for example, for reducing the cost of hospital care. It is a beginning, a very significant beginning.

The medicare problem is as great or greater than the social security problem in terms of funding. In fact, if not dealt with, it will be an even greater crisis than social security is at the present time.

Now the administration has proposed a prospective payment plan which will reduce, hopefully, hospital costs, give hospitals an incentive to be cost effective for the first time, and reward them in doing it. I do not suggest this as a total answer; I say it is a very good beginning.

Through the administration's proposals this year and in subsequent years we expect that there will be cost savings down the line.

We expect that we will be able to save the medicare fund but, nonetheless, there are going to be needs for other answers. For example this year the administration is proposing increases in the copayment responsibility of recipients, but offering at the same time catastrophic coverage for the last illness, not only a subject of great financial concern for our older citizens, but also a matter of terrible anxiety in their lives. I think this proposal goes a long way toward retrieving that anxiety in a responsible way; it will, if passed by the Congress, avoid that kind of extra tension.

Obviously, the Congress and the administration will have to look at medicare in its full funding context, and I can only say, Senator, that I will be very happy to work with you.

Senator KENNEDY. I would welcome it because, even though you have proposed prospective budgeting—and I am strongly for prospective budgeting—what you are going to find if you limit it to medicare is that you are going to see cost shifting. The savings will just be picked up by other parts of the health care system.

Second, I am enormously concerned about the issue of assignment, the number of physicians that are prepared to accept medicare rates of payment. If a patient has medicare and medicaid, they cannot avoid it.

In States across this country there are increasing numbers who refuse to take assignments. That is going to have an important impact on the affordability of health care by our senior citizens. I hope we will have a chance to review that with you.

In the administration's prospective payment proposal you have no requirement for the establishment of fees for physicians. You cover hospital costs but not physicians' fees. I think we will have a chance perhaps to get into that issue somewhat more.

Mr. Chairman, time has moved on.

I will welcome the opportunity to work with the Secretary on these areas. I just touched on them very lightly here but would like to go into greater detail. I would like to ask on behalf of all the minority that we have the record left open to submit some other questions in areas where we have important interests.

The CHAIRMAN. I think we can keep it open. I would like to have the questions in by the end of the day, however.

Mrs. HECKLER. Might I just say, Mr. Chairman, that there will be a 1-year freeze on physicians' fees, the salaries of physicians under medicare. There will be a 1-year cap.

I can understand your position. As you know, the administration's proposal goes only to medicare, but it is hoped that the methodology developed will then extend to the other areas of the country.

Senator KENNEDY. That is the best news I have heard from a prospective Secretary.

Mrs. HECKLER. Not by fiat but by——

Senator KENNEDY. Well, we can work out the details, but there is no question that if we start with that concept and recognize the importance of it, I give credit to the administration for recognizing the concept. We had difficulty in the last administration getting them to recognize even the concept in terms of prospective budgeting, quite frankly. This administration has recognized it. The problem is you have the cost shifting, and we have to deal with that, I think, in a way that is going to insure that we are going to have good quality health care and people are going to be treated effectively but that we are going to be able to do something about this absolute explosion of health care cost that is devastating to the elderly and is, I think, backbreaking to middle income families who see their premiums on insurance going up 15, 18, 20 percent per year, and the flow lines for that, as you know, Mrs. Heckler, are just absolutely up through the ceiling. Unless we are going to be prepared to do something on that, I think we will have missed an important opportunity.

Thank you, Mr. Chairman.

The **Chairman**. Senator Stafford.

Senator **Stafford**. Thank you very much, Mr. Chairman.

Mrs. Heckler, I look forward, as the others do, to working with you in the years ahead and, with goodwill, working out many of the problems that we may find we are mutually encountering.

I do have just a few questions.

One has to do with reorganization of the Office for Family Planning. In light of recent administration actions affecting the title X program family planning, there has been considerable public interest in your position on family planning. Am I correct in my impression that you support the title X program and view it as a basic preventive health program?

Mrs. **Heckler**. I definitely do, Senator.

Senator **Stafford**. Thank you.

Just a few days before former Secretary Schweiker, one of our colleagues in both Houses, announced his resignation, he ordered that the Office for Family Planning be moved from the Bureau of Health Care Delivery and Assistance and placed in the Office of the Assistant Secretary for Health. This is the first time in the program's 12-year history that it has been isolated from other established health service delivery programs and taken out of the hands of career public health professionals to be administered by a political appointee. Since the program has been effectively administered in the past in accordance with the congressional intent, and since former Secretary Schweiker assured me and other Members of Congress last summer that "This program should be located in the Bureau of Health Care Delivery and Assistance," perhaps you can explain the rationale for this move. If it is too soon for you to be able to do it, maybe you could do that in writing.

Mrs. **Heckler**. I would be happy to submit it in writing when I return my responses to written questions submitted to me.

I want to say that I personally will be very interested in seeing that the will of the Congress is fulfilled on family planning, and that will not be in any sense diminished by the consolidation that Secretary Schweiker put into place.

Senator **Stafford**. Under the reorganization, will the role for the Department of Health and Human Services' regional offices, in making grants for family planning services, be changed?

Mrs. **Heckler**. Not at all, Senator.

Senator **Stafford**. If there is good reason to believe that the move of the Office for Family Planning is detrimental to the goals of family planning programs and not in the best interest of those who depend on its services, would you as Secretary consider returning the program to the Bureau of Health Care Delivery and Assistance?

Mrs. **Heckler**. At this point, not having taken charge of this Department, as I see it my mission is to make this program work. I would hope that I could accomplish that.

Senator **Stafford**. Finally, the President's budget of $24 million in the developmental disabilities program is a 43-percent cut in the State grant program. My question is, Do you feel that with the magnitude of this cut that persons with developmental disabilities will be adequately served?

Mrs. **Heckler**. Senator, that was a question which occurred to me, and it is one that I raised with Department official when I was briefed on the new budget figures. The explanation I received was the one I gave to Senator Weicker earlier—that this was designed to achieve a management efficiency and a bureaucratic reduction, but not to cut or curtail the services to the disabled.

At this point, the information I have is really limited to that input. I would say that I will pursue this, to see that the mission of the program is carried out. I am very concerned about the services to the disabled and that would be my goal.

Senator **Stafford**. Thank you. I look forward to working with you.

Mrs. **Heckler**. Thank you, Senator.

Senator **Stafford**. Thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Stafford.

Senator Randolph?

Senator **Randolph**. Thank you very much, Mr. Chairman.

Perhaps in the lighter vein, I am delighted that the present administration halfway through its tenure in the first of what might be later terms has nominated two women for positions within the Cabinet. I do that so that I may say that President Franklin Roosevelt did that on the first day that he served as President of the United States in March 1933. I hope the present administration will remember that at long last it has the responsibility to recognize women such as yourself who are capable and able——

Mrs. **Heckler**. Thank you.

Senator **Randolph** [continuing].—to hold these Cabinet positions.

Mrs. **Heckler**. I might say, Senator, there is a third woman member of the Cabinet, or person in the Government with Cabinet rank—Mrs. Kirkpatrick. I think that President Reagan is the first President to have nominated three women to that level of Government service.

Senator **Randolph**. I understand. [Laughter.]

Mrs. Heckler, I want to ask you a very important question. We have the Consumer Patient Radiation, Health, and Safety Act, that became Public Law 97-35. It required the Department that you will head to publish regulations for minimum training and certification for X-ray equipment operators. Now the date set by the law for publishing those standards was August the 1, 1982. That is, as you would know, nearly 8 months ago.

Would you tell the members of the committee if there is a cause for the delay in publishing the standards and when would you think they will be published, or what action would you take toward that end?

Mrs. Heckler. Senator, I cannot give you a complete explanation for the time-consuming nature of the Department's response, but I can tell you that I intend to expedite the publication of these regulations and will personally oversee it.

Senator Randolph. Thank you very much, Mrs. Heckler.

Only for the record, it was 1968, 14 years ago, that I offered the original consumer/a patient radiation legislation. Even today, the need for it is indicated in that there are only 13 States that now have the training and certification requirement. This continues to concern me.

I could give today documentation on those who have used X-ray equipment and actually burned the patient almost into death because there was no training program, no certification.

I shall place in the record the names of the 13 States that now have licensing laws, with your permission, Mr. Chairman.

The Chairman. Without objection, we would be happy to do that.

Senator Randolph. I would also place in the record the three States that have possible laws that are pending in their legislative bodies.

[Material supplied for the record follows:]

INFORMATION, SUBMITTED BY SENATOR JENNINGS RANDOLPH, WITH REGARD TO STATES THAT NOW HAVE MINIMUM TRAINING AND CERTIFICATION REQUIREMENTS FOR X-RAY TECHNICIANS, AND THOSE STATES WITH LEGISLATION PENDING BEFORE STATE LEGISLATURES:

Thirteen States have enacted and implemented or begun to implement licensure laws that regulate the practice of radiography: (as of May 21, 1982):

- Arizona
- California
- Florida
- Hawaii
- Indiana
- Kentucky
- Montana
- New Jersey
- New York
- Oregon
- Vermont
- West Virginia
- Puerto Rico

Three additional states have enabling legislation for licensure:

- Delaware
- Iowa
- Minnesota

State having authority to promulgate rules establishing technical qualifications for personnel, but no present plans to do so:

- Michigan

Senator Randolph. This is a very important matter.

Mrs. Heckler. It is.

Senator **Randolph**. It is a very crucial matter. It certainly is satisfying to me and to members of this committee, and I am sure to people generally, that you propose to move in an expeditious manner, in reference to this subject.

I know that you have been a member of the House Veterans' Affairs Committee. I am a member of the Senate Veterans' Affairs Committee. I know about your concern for the health effects of the herbicide agent orange. Obviously, in your new and important role as that person within the Cabinet Council on Human Resources, you will now have the opportunity and responsibility, a responsibility which I know you will undertake quickly, to review and consider this important matter. It is my belief that the interagency orange group, which reports to the Council on Human Resources, is, let's say, ready to focus attention—we will call it that—on the coordinating of the Federal effort, particularly scientific studies that relate to agent orange.

What are your plans, Mrs. Heckler, on the use of the agent orange work group, to resolve the concern that surrounds the exposure of individuals to the agent orange?

As you know, the chairman of that work group, James Stockdale, left the agency about one month ago. Do you plan to appoint to this important post an individual that you feel can do the job and, hopefully, will you make that appointment within a reasonable time?

Mrs. **Heckler**. Senator, my interest in agent orange does continue after having served on the House Veterans' Affairs Committee for 16 years. I am very aware of the problems.

I certainly will work closely with the working group that is already in place and will work to replace Mr. Stockdale as quickly as possible.

I can say that a great deal of very significant research is already being conducted under the auspices of this Department at the Centers for Disease Control in Atlanta, and they are conducting studies of dioxin poisoning and agent orange. I would say that I will be monitoring this with a great deal of personal interest and will pursue the concerns on this subject that I had earlier expressed so openly as a Member of the House.

Senator **Randolph**. It is reassuring to me and to other Members. I like the way you answer. You come forward and say what you are going to do, at least in the areas in which I am questioning you.

I want to go back to 1972. It was in this room that we established the Subcommittee on the Handicapped. There was no subcommittee in the Senate of the United States at that time. At the present time the chairman of our subcommittee is Lowell Weicker, a capable chairman. We have had Chairman Stafford, as ranking member. At the beginning and for many years I served as the chairman of the Handicapped Subcommittee.

Within our committee we have brought a body of law into being to serve physically and mentally handicapped persons. There are so many handicapped programs that seem, just at this time, to be in trouble. We have to check those problems out and find the answers.

I have often felt, and this perhaps is not the place to say it, the real handicap is when people have anger in their hearts, malice in their hearts. That is the real handicap. Yet, people with anger and malice and envy in their hearts have, during the years, brought a body of law into being in reference to the handicapped of this country. They had to get angry in order that their voices be heard in the Congress.

I mention just one of the programs where 4,000 blind persons are now self-supporting. They averaged last year $14,000 in individual earnings. They sold $231 million worth of items, these blind vendors located in the facilities throughout the Federal, State, and local buildings and also private industry. The program that was implemented in 1936 when Franklin Roosevelt signed it into law was known as the Randolph-Sheppard Act for the Blind.

We have had not only the opportunity, but the responsibility to see to it that legislation to give the handicapped the opportunity to come out in the sunlight, to work rather than to be hidden in the corners, and that opportunity must continue.

I would like your assurance, and I know it can be given and will be given, that you are going to do everything that you can, to see that the laws that apply to education and other programs for the handicapped, that they not be shortchanged by any administration; is that correct?

Mrs. **Heckler**. Absolutely, sir. I have to say, though, that the "E" is out of the acronym for my Department now, as you know. So, education will be primarily the responsibility of Secretary Bell.

I have great respect for the handicapped, and throughout my political career have been concerned that they be given every opportunity to enrich their lives and to enrich our lives by their talents and contributions. In the role in which I hope to be placed shortly, I certainly will evince this concern for the handicapped. I will also say that I think the position taken by the Department today, its announcement requiring the posting of notice that the lack of providing sustenance or medical care to handicapped infants constitutes discrimination, is an extension of that concern for the handicapped. I hope to honor that concern in all elements of my service in the Government.

Senator **Randolph**. You are a Republican, aren't you? [Laughter.]

Mrs. **Heckler**. Mr. Senator, I have to say that the President cares about the handicapped as much as either you or I.

Senator **Randolph**. Just a moment. I say you are a Republican?

Mrs. **Heckler**. Proudly.

Senator **Randolph**. Proudly. I am a Democrat proudly, but there is no partisanship that should be shown in reference to the handicapped.

Mrs. **Heckler**. That is right.

Senator **Randolph**. Isn't that right?

Mrs. **Heckler**. I agree with that.

Senator **Randolph**. Bless you.

Mrs. **Heckler**. Thank you, Senator. [Laughter and applause.]

The **Chairman**. I want to compliment Senator Randolph for the years he has been a champion of the handicapped. We appreciate your comments here today.

Senator Quayle?

Senator **Quayle**. Thank you very much, Mr. Chairman.

Peggy, Madam Secretary, former colleague in the House of Representatives, welcome. It is great to see you again.

You know what your friends over there are going to say now that you have departed the House of Representatives and entered the administration, that it will be a great contribution to both institutions. They said that to me coming over here, and I am sure that your friends will say that to you as you embark on a far more serious course and one that I am sure that you will take to heart and do a very good job in.

I just wish you well.

Mrs. HECKLER. Thank you.

Senator QUAYLE. I know you will do a good job.

I would like just to express a couple of concerns publicly that we have talked about privately.

First is the issue of health care costs; rising health-costs. I think you pointed out very accurately that this is a national concern. Any time you see an 18-percent average health care cost increase where the inflation rate is now below 4 percent, there is something fundamentally wrong, and we have to recognize it.

I wonder if you would agree with most health economists that the increase in hospital construction adds to the health care costs in this country. Would you agree with that basic assumption?

Mrs. HECKLER. Obviously, hospital costs are affected by construction and the increase in the cost of construction affects hospital costs—one affects the other.

Senator QUAYLE. In other words, if you do have hospital construction, expansion and modernization of hospitals, it is in all probability going to add to the health care costs of the country as a bottom line? Would that not be a fair and accurate statement?

Mrs. HECKLER. I would say that would be fair and accurate, although I have to say that, in some cases, construction can—if it is replacement of a structure that was far less effective—be expensive, but in the long run a cost-effective alternative to an unworkable, unyieldy, out-of-date facility.

Senator QUAYLE. Basically, I think that the rule of thumb has been that if you spend a dollar on hospital, plant, and equipment increases, that really translates into operating cost increases of about 30 percent.

Mrs. HECKLER. I have seen those figures.

Senator QUAYLE. I think those figures are fairly well accepted.

Mrs. HECKLER. Yes, they are.

Senator QUAYLE. If that is the case, I wonder in the prospective payment legislation that is now going to be a main vehicle to address hospital costs and health care costs, if we might consider or reconsider the inclusion of the capital expenditure passthrough. I understand that you treat capital expenditures as a passthrough in the prospective payment proposal. If that is the case, what kind of a disincentive is that to hospitals to go ahead and build at will?

Mrs. HECKLER. Actually, I think that aspect of the prospective payment proposal does not have as much significance as the whole reform of the payment structure, which for the first time provides an incentive to the hospital for actually cutting costs. For the first time, the hospital will be able to assess what its income will be from specific procedures and then expect reimbursement on that basis. This allows them to be—and, in fact, encourages them to be—cost effective.

I think this does not solve all of the hospital cost problems, obviously, but it at least revises reimbursement. Having a further passthrough or considering the further significance of the capital cost passthrough does impose a new dimension. In fact, though I think that in attacking the problem as we do, we are dealing with the change of a system—the reform of services, the reform of payment—in such a way as to make it worthwhile for the first time for hospitals to be very cost effective.

Senator QUAYLE. What major mechanism do you think that you have at your disposal that you could institute to make hospitals think through their planning rather than just having a policy to go on and to expand at their own discretion? We basically have effectively eliminated the health-planning aspect. Some of us were talking about decentralizing health planning. For all practical purposes, it has been eliminated.

I just wonder what mechanism we have to take a cautionary look at whether we ought to have this piece of equipment or that piece of equipment. It is sort of like the military, quite frankly. These things are all nice to have. There is not one weapon that has been proposed that is not nice to have. I am sure that there is not one area, one additional expansion or piece of equipment that a hospital would like to have that is not nice to have, but whether it is really practical, whether it is going to work in a situation without overall adding to the health care costs—I just wonder what mechanism you think you have to review, these purchases or expansions, before they go ahead and buy or build.

Mrs. HECKLER. The Department feels that the major mechanism is really the discipline of having prospective payment settled in advance for diagnostically related groups of diseases or procedures. There is the discipline that prospective payment will impose. It will actually prompt the hospital to ponder its options for utilizing the income it receives, and the hospital will by that very nature be forced to choose the most cost-effective additions in terms of construction, equipment, or whatever. The discipline of prospective payment gives the hospital the option to invest in those procedures, in those new technologies that fall within the new DRG's, as they are called, and will allow the hospital the greatest cost saving. That, in itself, is a major discipline that has not been in effect for all these years.

Senator QUAYLE. There has been some skepticism about potential abuse of the hospitals on channeling moneys or channeling patient care or even having a number of physicians at the hospital that would be related to the high revenue DRG's. How are you going to monitor to make sure that the hospitals do not just focus in to the high revenue or the high payback on the DRG's?

Mrs. HECKLER. Actually, as you know, the DRGs, will be established on a national basis. At the present time, there is such a wide variation across the country in hospital reimbursement on just specified operations and procedures, that just establishing these basic DRG's will, in itself, create a reduction in hospital costs.

In terms of the revision of this program, certainly, the Department will be looking at it very closely, and the Congress will, too, in terms of the capital cost impact.

I have to say, Senator, that the House version of the prospective payment plan, which has just come out of the Ways and Means Committee, calls for a report within a year on the impact of the capital cost passthrough. We will review and monitor virtually all of this.

I think we have to presume that hospitals will respond to basically genuine needs, the needs of patients. I think it is rather cynical to assume that hospital treatment will gravitate to the most rewarding, financially rewarding, procedures rather than toward providing basic services that people need. However, there always will be a review by the Department.

Senator QUAYLE. If I could just take that a step further, would you say the House of Representatives has done enough by asking for an assessment of the capital expenditure passthrough, and also you are saying that we really are now just getting the DRG's in place and that not only you, but the Congress, will also be monitoring this very closely?

I wonder if it might not be prudent for us to reconsider on a 1-year or an 18-month basis a decentralized health planning program to work on monitoring these two things? We introduced this and talked about it last year. I talked to you about it privately.

I will be very honest with you. You have not been over there, and I hope that you can correct it, but there is perception in the country that the health planning system is in complete disarray and so let's go ahead and build. Let's build as fast and quickly as possible. You and I both know that if that is going to happen that there is going to be a tremendous push on the acceleration of health care costs. If that is the case, I just wonder if we might not want to think about a deregulated, decentralized health planning program to instill some sort of a semblance of order and to quash this perception that is out there to go ahead and build and buy.

Mrs. HECKLER. Right.

Senator QUAYLE. I only bring it up to dramatize the importance that you have, that this committee has. Quite frankly, I hope that you use that flair of independence of the Peggy Heckler that I knew over there in the House of Representatives and will come forth with some bold proposals to deal with the problem of unconstrained growth because it is a very, very fundamental problem.

I wonder if this might be a short-term remedy as we get into the prospective reimbursement and see how it is going to filter out, as we look to see how the DRG's are going to work.

Mrs. HECKLER. I can assure you, Senator, that I will always be a "heckler," and my independence has not disappeared. I will look at this independently and really look at the issue that you raise.

I do feel that the review of the health planning agencies has been so uneven, has produced such reports of uneven performance, as stressed not only in our departmental studies of health planning, but also in studies by the Congressional Budget Office and others, that that the response——

Senator QUAYLE. I agree with that. I think that the past administration of the health planning agencies in this country has been a shame. Because of the way that they have adjudicated and handled themselves in many respects, that is one of the reasons that we are in this situation today. I do not want to get into that category of going back to the same old bureacratic traps that we had in the past, but I certainly believe conceptually that there is a concern in how we are going to have the proper implementation of planning at particularly the local level.

There may not be any Federal role ultimately in this. It may all be done with the State boards of health and with the local agencies, but I do believe that we have to cure this perception.

I have 1 minute left. I have one other question.

Will you continue to support the teenage alcoholism initiative that was started under Secretary Schweiker?

Mrs. HECKLER. With a great sense of its high priority in terms of the national agenda. I feel strongly about that.

Senator QUAYLE. I do, too, and I think that there are others on this committee who feel that there has been some success made in the area of drug abuse with our young people.

Mrs. HECKLER. Yes.

Senator QUAYLE. However, as a result of that amount of success, we cannot give up our war of trying to educate about the perils of drug abuse, but now it seems that we really have a problem with alcoholism, not only with teenagers—and I believe that the teenage alcoholism initiative that the Secretary undertook was a very good one, and I am glad to learn that you are going to continue that—but you can even look at alcoholism in the private sector and how it reflects productivity.

I would hope that you would also, as you look into this, see if there is a way that we can coordinate the NIH activities with the National Institute of Alcohol and Alcoholism. I do believe that there is a gap there, and I would not propose at this time that we come forth with a new institute of alcoholism and drug abuse. I would not dare suggest that today, but I would just simply point out that, hopefully, we can come to grips and get a better understanding and look at this problem in a more profound way than we have in the past.

Good luck. I am sure you will do a good job.

Mrs. HECKLER. Thank you.

The CHAIRMAN. Thank you, Senator Quayle.

Senator Pell?

Senator PELL. Thank you very much, Mr. Chairman.

I have five questions I would like to get in within a short 10 minutes.

In Rhode Island we already have in place a successful prospective reimbursement system for Blue Cross-medicaid. Do you think the administration proposals for prospective reimbursement would be flexible enough to allow a State such as my own an exemption if we expand our voluntary plan and include medicare and demonstrate we are keeping costs below the specified level? Do you follow my question?

Mrs. HECKLER. Yes.

Senator PELL. Good.

Mrs. HECKLER. I would think that there could be a compatibility there.

Senator Pell. Right. There might be the possibility of an exemption?

Mrs. Heckler. There might be.

Senator Pell. You obviously hope very much so because we would be doing more for less.

Mrs. Heckler. You have a good record, Senator.

Senator Pell. We do, I agree.

Being from Massachusetts as you are, I know you have the same awareness that I do of the crushing impact that unemployment makes and that the recession has made in our area. I am wondering, as we see the people searching for work, the hardships that are presently taking place which were in your former congressional district and in my whole State—I am wondering why the administration believes we should take further cuts in AFDC, food stamps, child nutrition, and the like. It would seem to me this is just the wrong time for these proposals. What would be your reaction?

Mrs. Heckler. Senator, I think that the thrust of the administration's proposals has been to help the truly needy. The review of programs has produced surprising results in some areas in which benefits go beyond that basic scope—for example, in the welfare area—and have not taken people off the welfare rolls.

I think that we are looking at a very complex economic situation. Certainly, the unemployment problem is a severe one. At the same time we are looking at the issue of how to stabilize the economy of the country. We have made great progress in reducing inflation down to 3.9 percent from 12.5 percent. That is an economic gain for everyone in this society.

I think that in this area of balancing equities—dealing with inflation, dealing with the cost of Government, trying to reduce the cost, trying to preserve the safety net—the emphasis has been on taking care of the poorest of the poor, and that would be those on medicaid as well as medicare. Indeed, these services have been preserved.

The shifts that have occurred in the welfare area particularly have been designed to remove benefits from those who, either because they are not within the safety net or are in a sense "enriched" at the expense of others in terms of receiving benefits——

Senator Pell. I appreciate your reaction, but still I guess we have to agree to differ on this.

It would seem to me, for example, with child nutrition that this would be a good time to keep that or expand it, not decline it.

Mrs. Heckler. Senator, that is not a program in my Department. I have to tell you that. The WIC program and the——

Senator Pell. The AFDC is in your Department.

Mrs. Heckler. The AFDC program is, yes.

Senator Pell. Right.

In any case, I see your point, but I still think this is not the time to try to tighten up when people are in misery, which they are in our area.

Now I have another question. In connection with the parental notification concerning youngsters who seek birth control information, is it your intent to keep the regulation as it is or to modify it in any way?

Mrs. **Heckler**. Senator, I think my views are known. The regulation was, as you know, set into place before my nomination was actually announced. I have to say that I have always understood the position of those who took the other side of the issue, and they have a valid argument to make. They are concerned about families, and I am as well.

The policy was set by the President and has been set; I certainly will accede to the President's policies. In future policies that have not yet been cast in cement, I would have a voice.

Let me say this: This policy has been established and it is now in the court. Therefore, the Department is restrained from carrying out its regulation, and that will be the status of the issue until the courts resolve it.

As for any further action on the question, since the President has already made his judgment, I would simply carry out his policies, because that will be my role as a Cabinet Secretary.

Senator **Pell**. Thank you.

As you know, some of us are concerned about that regulation.

Mrs. **Heckler**. I know.

Senator **Pell**. We will keep pressing on that.

The fourth question: We have among the largest Hong—you know, the mountain people in Indochina—among the largest Hong population in the Nation. They were placed in Rhode Island as the result of Federal policy. If you are confirmed—and you obviously will be; I know you will be and look forward to voting for you—when you are confirmed, will you support maintaining the Federal commitment to the Hong? How will your Department's Office of Refugee Resettlement manifest this commitment?

Mrs. **Heckler**. The refugee resettlement policy has already been established by the Department and will be continued.

Senator **Pell**. Good. That is good news for us because we have, as I say, in the whole United States the largest concentration.

Finally, we are running into some problems of communication which I hope that you will be able to resolve. We have a hospital that has been classified as a rural hospital, although in an urban area, and they have been unable to arrange a meeting with one of your officials from the Health Care Financing Administration. I would hope that you would agree, when you go back to the Department, to make sure that these people agree to sit down with our hospital president and officials.

Mrs. **Heckler**. I certainly will see that that is done, Senator.

Senator **Pell**. Thank you very much. We will make sure he knows it, too. Thank you so much.

I look forward to voting for you.

Mrs. **Heckler**. Thank you, Senator.

The **Chairman**. Thank you, Senator Pell.

Senator Nickles?

Senator **Nickles**. Mrs. Heckler, I have enjoyed listening to you and your responses before the committee I think have been very well made.

I mentioned to you in my opening statement my awe of the responsibility that you have in trying to administer an agency that has a budget scheduled for next year of $289 billion, an enormous responsibility if it is to be managed properly.

Looking back over the last couple years, I mentioned that the Department's budget is almost $100 billion more than it was in 1980. Between 1980 it went from about $194 billion to now almost $290 billion. Sometimes points such as these need to be made because too often we hear people talk about the lack of commitment by the administration for health and social services, et cetera. These figures do include social security, another issue which we hear people talk about a lack of commitment for.

I am really coming from the other side. I have, out of interest, gone back a few years and see that in 1970 for health and human services—and at that time it included education—we were spending $52 billion. For next year's budget we are looking at a budget that is almost six times what it was 14 years ago.

Mrs. **Heckler**. Right.

Senator **Nickles**. That is a tremendous rate of growth and increase. We have heard many talk about medicare and medicaid. I think we all share a desire to provide quality health care to the extent possible and affordable, but in looking at medicare under your budget you are talking about medicare for next year at almost $60 billion. In 1980 it was $35 billion. This is a tremendous increase in medicare and, correspondingly, a large increase for medicaid.

I would hope that as part of the administration, when people talk about cuts, you would go back to last year's figures or the previous year's figures and say how much of an increase there has been.

I had somebody talk to me in Oklahoma saying, "You are cutting medicaid and medicare."

I said, "We are not cutting it. We are only slowing the rate growth * * * trying to get control of the program."

I feel that point should be made.

I had questions in my opening statement. My staff has been working on this for several months as well as Congressman Erlenborn in trying to see whether we could come up with steps to protect handicapped infants.

Are you familiar with the program CBS is now airing in Boston?

Mrs. **Heckler**. I have heard about it.

Senator **Nickles**. I had the pleasure of seeing parts of that today. Needless to say, it needs greater exposure and I hope there will be more direct involvement by the administration in prosecution.

You cited section 504, the Rehabilitation Act of 1973, where it states it is unlawful to discriminate against handicapped infants or children on the basis of their handicap. Yet, we have seen it not only in Bloomington and in other places, but it is happening on a much, much broader scale than what has been known.

Again, I compliment you for the notice today that you are making, posting a hotline number.

What steps will be taken? Let's assume somebody calls up and says somebody is starving this child to death because they are handicapped, they have some other type of medical disability. They are in the process of killing this child. What steps will be taken?

Mrs. **Heckler**. Actually, I am quite appalled at the information I am receiving on the incidence of allowing children, by deliberate edict, to simply starve or be denied essential medical treatment as a conscious policy, which is what has produced this regulation.

Of course, the President feels very strongly about this and did send a message of concern to the Department on the issue. I know he feels very strongly about this.

The notification we have set into place, as you know, will make the local health care facilities, those health care providers who are particularly involved with infants, aware of the fact that if the infants are not provided with necessary food, nourishment, or essential care, if they are not taken care of, it would be a violation of law.

Our first response would be to go to the State child welfare agency, to investigate the issue. At the same time, we will alert our local regional HHS office to pursue the report.

The issue then would be brought up, the investigation would be carried out, and should the violation continue, this would allow for the protection of rights in a court of law. The issue will be brought to the Justice Department should the facts warrant that action. This would be a procedure which will allow the infant's case to be heard and allow the infant to be cared for under the law.

Senator NICKLES. Again, let me compliment you for the initial steps. I want to be sure we go further. Section 504 was the law before Bloomington.

Mrs. HECKLER. Yes.

Senator NICKLES. If I remember the case, it went to court and the judge ruled they had that right, which I think is a misinterpretation. However, if that is the correct interpretation of the law, possibly we should seek to solicit your help in trying to tighten up section 504 in whatever manner necessary to make sure that is not the law. I do not see how it can be. I will not read it because you have read it before.

Mrs. HECKLER. I have.

Senator NICKLES. That is an absurd interpretation but it is still going on.

Today we hear rumblings about a possibly similar incident in Texas. The more I look under the tent, the more I see of this. It is much more prevalent than most of us would even care to know. It is a very hideous type of thing.

I am also concerned about this: How many instances of this type have been reported to the Department since the Bloomington case?

Mrs. HECKLER. We have only had seven cases reported to the Department. However, we feel that with the notification to the health care providers, the protection of confidentiality on the part of the informer (nurses in a hospital, for example) and with the hotline procedures, we will probably deal with the really serious dimension of this problem.

What has appeared is a scattering of a problem and, one thinks, a widespread problem. Yet, the actual cases brought to the Department are very few in number.

A reason for this, for example, is that people have said nurses were afraid to intervene with a hospital order, not to feed a baby, because they were worried about their own jobs or how to report the incident. This is why we are acting now to post notices to have such cases reported in 15 days.

I think this procedure, working with the States and backing up the State agencies with our own HHS investigation, will allow us to determine what violations of Federal law have occurred. It would also allow the issue to go beyond a State court, because violations would be of a Federal statute, which provides for protection of the handicapped.

Senator NICKLES. Would you give us a status report on those seven cases?

Mrs. HECKLER. I would be very happy to do so.

Senator NICKLES. I would appreciate it.

Mrs. HECKLER. Yes.

Senator NICKLES. What I am concerned with is that we may have some of these cases unreported and I believe your posting will help. However, I am also concerned that, according to the report I saw earlier today, that very knowledgeable people are making these decisions on a willful basis. They have knowledgeable of the law but make these decisions anyway.

If we do not have prosecution, if we do not have existing law carried out, then people will disregard the law and we would have to go further. Whether we have to cut off funds or prosecute through the Justice Department, whatever it may be, those actions have to be taken and not a mere going down to some bureaucrat who says, "They called a year ago but the investigation has not started" or "Maybe the investigation is not complete."

Of course, we are talking about a short period of time for that infant's life and a domino thing if we do not really get this stopped, and I think it will take publicity and prosecution as well. You are talking about doctors and hospitals involved. It will take that type of aggressive prosecution to be able to put a stop to this type of activity.

Mrs. HECKLER. Senator, we are very, very firm in our commitment to the enforcement of the law. I think that those who might have questioned the will of the Government to stand behind the law will have that uncertainty resolved.

Senator NICKLES. What penalty would they face? Let's say you have a doctor at Johns Hopkins or elsewhere and they decide this is what they will do.

Mrs. HECKLER. Certainly a federally assisted hospital could face the loss of Federal funding.

Senator NICKLES. We are talking about medicare and medicaid?

Mrs. HECKLER. Yes. We are talking about hospitals, many of which derive a great deal of their revenue from these sources.

We also have the question of further prosecution by the Justice Department. That would depend on the assessments, investigations and very prompt response.

One of the primary designs of the new regulation is to have the opportunity for a fast response through the hotline mechanism, with which the Department has had experience. Therefore, we would use an existing hotline system concept, and put this in place. What we are talking about is not a proposed rule but an interim final rule which will become effective 15 days after being published.

We will receive comments from the departments and from those affected agencies throughout the Government, but at the same time the rule will be in place and the violations will be the subject of this new notice.

This will be a very dramatic shift in Government policy, not a shift in the law, but a shift in enforcement: We expect to stand behind this enforcement procedure.

Senator NICKLES. I look forward to receiving your status account on those seven cases.

Mrs. HECKLER. I would be happy to supply them.

Senator NICKLES. I could not encourage you more to take a very rapid and strong enforcement position. If it has not already been taken, which I do not think has been the case in the past, I think it is crucial that it be taken and I look forward to working with you on it. If it takes that sort of change, we would be willing to assist you in that area as well.

Mrs. HECKLER. Thank you, Senator.

The CHAIRMAN. Thank you, Senator Nickles.

Senator Denton, you have been very patient.

Senator DENTON. Thank you, Mr. Chairman.

Mrs. Heckler, I have been here only 26 months and I have been to a number of these hearings but I have never heard anyone answer with more precision and confidence. I never have been more impressed by a nominee before. I would say that I feel a sense of good news and bad news about that, the bad news being that somewhere in Massachusetts a Democrat is so formidable that he defeated you, and the good news is that Massachusetts' loss is our country's gain.

You seem compassionate and realistic but also tough about trying to achieve that true compassion with a dollareffective set of means. I would have asked a number of questions already asked, but I have been very satisfied with your responses.

Would you care to elaborate at all on your well-known views on abortion, particularly any thought you might have about a greater HHS involvement in promoting adoption as an alternative to abortion, or even as an alternative to the apparent peer pressure which young unwed mothers feel to raise their own children, sometimes in situations which are not likely to be beneficial to the child?

Mrs. HECKLER. Senator, I simply say that our Department will place a great emphasis on enhancing adoption, indeed, on providing assistance to prospective parents and on really fulfilling the whole promise of adoption as an answer.

I have to say in regard to Senator Nickles' earlier comment about the difficulty of this assignment that, based on my own prolife convictions, I feel I have the resources of the Lord behind me to help me do what I hope to do. I think those of us who take the prolife position and the right-to-life position are concerned as well with the opportunities for adoption, and even in the handicapped infant's case.

Sadly, in the Bloomington case, over 10 people were interested in adopting that baby. It is so sad that life was lost.

I have had the great and enriching pleasure of meeting so many parents of adopted children who are severely handicapped, many of them having several adopted children who are handicapped. The richness of their lives, as they describe it to me, is quite inspiring.

In terms of adoption, my support there is wholehearted and strong. I cannot give you a fast and easy answer on the second element of your question, Senator. I think one has to deal with the individual rights of a mother. Indeed counseling plays a role there, and it should be effective counseling. Nonetheless, she has that ultimate right to determine custody.

Senator **Denton**. From what I have seen in looking into it, there is a lot of child abuse evolving out of that relatively new propensity for 97 percent to keep their young rather than putting them up for adoption. Adoption was more or less the preference in the past decade.

I cannot help but commend you for the special emphasis you placed upon praising the HHS regulation referred to by my friend, Senator Nickles. In my subcommittee we will soon be getting into that issue through the Child Abuse Prevention Act.

Mrs. **Heckler**. I think that is appropriate, Senator. I think cruelty to a handicapped infant is the earliest exhibit of child abuse. Child abuse at the earliest stage occurs in infancy, at a time when, obviously, infants are so totally helpless to speak for themselves. This issue has to come within the purview of child abuse as well as the civil rights of the handicapped.

Senator **Denton**. I don't know how far you have been able to read yourself into the recent laws and bills in your field, but in the context of your views on pregnancy and abortion, have you come on the adolescent family life program which this committee passed last year—with a slightly different membership—and which I think would be passed again with the committee's membership this year? If you are familiar with it, how do you evaluate it in the context of your views on pregnancy and abortion?

Mrs. **Heckler**. It is a program worthy of consideration and one which has a great deal of value.

Senator **Denton**. For the record, because of Senator Stafford's comments regarding the reorganization and the requirement that we follow congressional intent, I would for the record like to refer to the law of 1970, title X of the Public Health Service Act, section 3, which states,

> There is established an Office of Population Affairs to be directed by a Deputy Assistant Secretary for Population Affairs.

Section 4 states, "The Secretary"—which will be you—"shall: one, administer all Federal laws"— . . . —"which provide for or authorize the making of grants . . . to family planning programs."

So, in addition to the legislative language which would make the reorganization mandated, there is a 1978 Select Committee on Population report prepared by that committee in the House in the 95th Congress which, upon reflection upon that previous law, recommended as follows in section 33 of that law:

> The Federal Government should place coordination responsibility for family life and sex education in a single unit such as the Office of the Deputy Assistant Secretary for Population Affairs . . . at HEW. Thus far, funding has been administered through a variety of Federal grant programs.

As subcommittee chairman having jurisdiction over that area, I totally agree with that which was done in the Democratic House under President Carter, the reorganization effected under Secretary Schweiker for which you have stated your support, and believe that to have, as we now do, the Office of Population Affairs as originally envisaged, including family planning and the Adolescent Family Life Act, all on one, follows congressional intent.

Mr. Chairman, that concludes my remarks.

The CHAIRMAN. Thank you, Senator Denton.

Are there any other questions?

Senator NICKLES. In recognizing your support for the planning aspect of your Department, would you agree with me that individuals and groups which receive funds from that should not use those funds in any way, shape, or form for political purposes?

Mrs. HECKLER. Absolutely. I certainly would say that the purpose of the act was to allow the funds to be used for family planning purposes.

Senator NICKLES. I have an ad I want to show to you. It bothers me. "If you have a miscarriage, you could be prosecuted for murder. Abortion is something personal, not political."

Could you supply me with information on how much money Planned Parenthood receives from your Department under title X, and whatever various titles from which they might receive financial assistance?

Mrs. HECKLER. Yes, I certainly would be happy to do so.

Senator NICKLES. In all seriousness, there has been a lot of political activity coming from this group, not so much in counseling or trying to prevent unwanted pregnancies. I am very concerned about the total amount of money we are giving that agency and how much of it is used in this way. They have a notation, "Not paid for by political funds," but it has come to my attention in the past we are supplying funds to them.

With your help, I can find out whether this is correct, but half of their budget came from the Federal Government. If that is the case, I would think possibly some changes or restrictions would be in order because it has become very militantly political and very much removed from what they are supposed to be receiving those funds for.

If so, perhaps those funds should be redirected or constrained in some way.

Would you supply my office with the amount of money that they received in 1982 or it is planned for them to receive in 1984? Actually, 1982 would be most concrete. I would rather work with concrete figures.

I resent this type of ad and resent the fact that indirectly my tax dollars are going to subsidize this type of ad in one way or another. I would like to see that change implemented if we can do it.

The CHAIRMAN. I think the Senator makes a good point. Even if those ads are paid for by private funds, they could not have the ability to use those private funds without Federal funds paying for everything else.

If what Planned Parenthood is doing is what we have seen here, it seems to me they should do what they feel is ethically and morally right rather than getting involved in politics. I think it would perhaps solve many of the problems which exist in the Congress itself. It is something which should be looked into.

Mrs. HECKLER. I will provide the information to your office and for the record. I will give you the funding information as specifically as it is identified at the Department.

Senator NICKLES. I would appreciate it.

The CHAIRMAN. Thank you.

Mrs. Heckler, there is no secret about the fact I think you are one of the best appointments this administration has made. I am very proud of this appointment.

This is a tough committee with a lot of tough issues. They are people issues, and we have around 3,000 different statutes we administer, a number of which will be within your jurisdiction as Secretary of Health and Human Services.

All I can say is that I think everybody here has been impressed with the manner in which you handled yourself today and we expect to enjoy the coming months and years when we work together.

I want to thank you for appearing before the committee. We appreciate the effort you have put forth and those of your associates with you.

[Responses to additional questions subsequently submitted to Mrs. Heckler follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

April 14, 1983

The Honorable Orrin Hatch
Chairman
Senate Labor and Human
 Resources Committee
Washington, D.C. 20510

Dear Mr. ~~Hatch~~: Orrin

Attached are the answers to the questions we received from the committee members after Mrs. Margaret Heckler's courtesy hearing with the Senate Labor and Human Resources Committee. Due to heavy time commitments for staff devoted to preparing for the House and Senate Appropriations hearings, we have taken longer than I'd expected to get these back to you.

I appreciate your patience and understanding. If there is anything further we can do, please call.

Sincerely,

Tom

Thomas R. Donnelly, Jr.
Assistant Secretary for
 Legislation

Senator Hatch

Q: There was substantial controversy created by the Administration's proposal to reduce indirect costs of NIH grants by 10% across the board in the FY '83 budget. What is your position on this issue?

A: This issue has indeed been one of concern, particularly because indirect costs have been consuming an ever-larger percentage of our research budget. As you know, House Appropriations Committee report language directed the Department "to make a careful review of this matter, to consult with universities and other research organizations, and to submit a report setting forth conclusions and making recommendations to the Committee." The Department now is developing the report on this matter. I will make a decision concerning this difficult problem after I review the completed report.

Q: How does HCFA plan to meet the R&D requirements in the recently passed Orphan Drug Act?

A: HCFA is in the process of analyzing its R&D home health activities in order to determine what additional steps will be needed to meet the requirements of the Act.

HCFA is currently involved in a National Channeling Demonstration that is looking at the population most at risk of institutionalization and alternatives to institutional placement for that population. We believe that this demonstration will be very useful in helping HCFA to fulfill the requirements of the Orphan Drug Act.

We are planning to issue an RFP this year for a home health prospective payment demonstration project.

Hatch

Q: Secretary Schweiker has developed a Teenage Alcohol Initiative directed at reducing the ill-health effects and deaths resulting from teenagers who misuse alcohol and drugs. While I am fully supportive of most of this Initiative and fully supportive of public and private efforts that prevent alcohol misuse, it has come to my attention that this Initiative has, in the past, endorsed "responsible" use of alcohol by minors. Do you intend to continue in this direction or clarify that drinking by individuals under 18 (or 21 in most States) is illegal?

A: It is a misunderstanding that the initiative endorsed responsible use of alcohol by minors. The initiative did not, nor will it in the future, endorse responsible drinking by minors.

Laws vary from State to State — but in every State, it is illegal to sell alcoholic beverages to persons under 21 (or 18) or for minors to purchase, possess, and/or consume alcoholic beverages. In addition —

a. alcohol-related accidents are the leading cause of death among young people aged 16-24

b. alcohol consumption has great potential for other physical and psychological damage

c. alcohol consumption is commonly associated with initial drug experiences among youth

d. alcohol is particularly dangerous when used in combination with other drugs.

For all these reasons, all our efforts to reduce alcohol-related problems among young people, including the Initiative developed by former Secretary Schweiker, strongly discourage the consumption of alcohol by young people. The materials developed for use in our programs have been revised to make our views in this matter very clear and to support and encourage young people in the development of skills necessary to saying "no."

Hatch

Q: Are there further efforts, besides the Health Incentives Package, within the Department of Health and Human Services to address the double-digit inflation currently experienced in health care?

A: Yes. The health care promotion and prevention activities of the Public Health Service have an impact on health care costs. Through these programs, we are attempting to influence people to take preventive measures and adopt more healthy life styles; that is, to eat properly, exercise regularly, and obtain necessary immunizations. Taking preventive measures and modifying behavior can substantially reduce the need for acute health care.

Through research at the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration, we are looking for better ways to prevent and treat illnesses and injuries. Through the Food and Drug Administration, we are expediting the drug review process to insure that Americans have access to beneficial drugs as soon as possible. In addition, this year we again are seeking to eliminate the burden of the health planning program which has enormously complicated the introduction of new technology into health care and impeded the competitive forces of the free market.

As you can see from this brief review, many of our program activities are oriented toward slowing the rising costs of health care.

Hatch

Q: Mrs. Heckler, how do you view the role of science in the development of regulatory policies and other areas where scientific issues or assessments serve as the basis for decisions and actions by FDA or other functions within HHS?

A: I believe that, in order to perform a regulatory mission involving the safety of such varied products as foods, drugs, biologicals, medical and diagnostic devices, radiological products and cosmetics, in an effective way, we must rely heavily on our own science. The scientific and policy complexity of the types of issues we face today require a sophisticated internal science capability to enable us to make informed decisions. It is this internal science capability that we must rely on when we defend these decisions either in a court or in the scientific community. I believe that it is our science base that lies at the heart of scientific regulatory agencies such as FDA, and that this base forms the underpinnings of our decisions.

However, as you know, science is never complete and it is rarely conclusive. Any regulatory system must also recognize the dynamics of science. Our present capability in the power of analytical resolution is many orders of magnitude greater than it was 50 years ago. In many instances, our ability to measure has outstripped our ability to understand the significance of our measurements, and we must accept that we are going to have to decide some issues on the best available evidence, interpreting the relevance of scientific data as they are applicable to man.

This task, with its infinite complexities, is one in which we frequently turn to seek advice from outside scientific experts. No single institution can successfully overcome the regulatory challenges being thrust upon us by increasingly powerful and creative technology. I believe that pooling our talent and resources with those available outside will enable us to deal effectively with this most important challenge, and succeed in our mandate to protect the public health.

Hatch

Q: What is your view regarding the need for independent scientific peer review of scientific data as a prerequisite to regulatory and other federal actions?

A: I believe that we must at times seek the advice of outside experts in dealing with the complexities of issues that we face. With increasing frequency we turn to outside experts either individually or in committees for assistance in evaluating critical scientific issues. Currently FDA utilizes standing advisory committees in the evaluation of drugs and devices. In addition, FDA has used and will continue to use, as the need arises, ad hoc advisory committees to evaluate the safety of food and color additives. The assistance they provide in evaluating the significance of scientific research results, to aid us in making regulatory decisions, is invaluable.

Peer review, which I would like to distinguish from scientific advisory committee review, is traditionally used by scientists to mean review of research findings by a group of scientists not affiliated with the institution in which the studies were conducted. The purpose of this review is to consider whether the scientific results are reproducible or due to some artifact, and must consider whether the scientific conclusions drawn from the study are adequately supported by the scientific evidence developed. Frequently, scientific advisory committees assume that the research results in question have already received adequate scientific peer review, and tend to focus on what recommendations are appropriate for regulatory action. At times, however, advisory committees integrate scientific peer review into their overall advisory committee activity.

I believe that review by scientists both inside and outside Government is important. In accomplishing this review it is necesary to involve those experts outside of Government early in the regulatory process, thus permitting the use of experts to be concentrated more fully on the scientific component of decisionmaking while maintaining a clear focus of responsibility and accountability for overall decisions.

I also believe it is important to maintain the efficient and credible use of outside scientific experts by reducing and focusing the numbers of issues so that only issues of significance are considered.

The quality of review must be consistently high and the best scientific expertise should be used for each issue under investigation. To best accomplish these aims I believe the agencies and their chosen experts must work closely together, and thus should not be separated.

Hatch

Q: Do you have any thoughts about what changes you would recommend for revising the Food, Drug, and Cosmetic Act regarding this Nation's food safety policies?

A: I intend to continue the work of former Secretary Richard S. Schweiker in association with the Cabinet Council on Human Resources. The Sub-Cabinet Council Working Group on Food Safety has completed an in-depth re-evaluation of the food safety laws and will continue to assist us in developing a fruitful dialogue between concerned trade associations, consumer groups, scientific organizations, and Members of Congress.

Five key issues related to food safety have been identified for analysis. These are:

a. Change FDA's Delaney "Anti-Cancer" clause away from a "zero risk" concept;

b. Explicitly define "safe" in the FD&C Act;

c. Provide for the utilization of risk assessments in issuing or revoking food additive regulations;

d. Utilize scientific review procedures in making food safety decisions; and

e. Authorize gradual phase-out for certain food and color additives as well as new animal drugs.

Q. Could you tell me when the Department expects to have the End Stage Renal Disease payment regulations ready for final publication?

A. As you know, since I appeared before your committee I have been confirmed as Secretary. Subsequently, I signed the proposed ESRD regulations on March 23.

Hatch

Q: According to a G.A.O. audit of Title X family planning clinics, evidence was found that some Title X grantees were unaware that it was illegal to perform abortion-related or lobbying-related activities with Federal funds. The Department of Health and Human Services concurred with G.A.O's recommendations that regulations needed to be clarified. What is the current status of these regulations?

A: As you indicated, the General Accounting Office (GAO) report of September 24, 1982 recommended that the Department establish clear operational guidance on the scope of abortion restrictions in the Title X program. The Department will develop guidance on the scope of the Title X abortion restriction. The Assistant Secretary for Health is undertaking this effort and will make a recommendation to me concerning the substance of this guidance and what form it should take.

Q: What is the current status of the "Conscience Regulations" which prohibit hiring discrimination policies by Title X recipients against medical personnel and staff who are anti-abortion? Do you support these regulations?

A: As you know, a section enacted as part of the Health Programs Extension Act of 1973 [illegible] prohibit discrimination against medical personnel on the basis of their religious beliefs or moral convictions respecting abortion or sterilization procedures. This provision protects those who are opposed to such procedures as well as those who favor them. I am very supportive of this statutory provision. In fact, as a member of Congress, I introduced several bills on this subject. The issue of the lack of regulations implementing this statutory passage was raised several months ago. The decision was made to develop regulations and staff are currently working on them.

March

Q. What is the current status of the proposed Medicare regulations on conditions of participation? Are major changes anticipated before final publication?

A. The proposed changes to the conditions of participation were published in the Federal Register as a Notice of Proposed Rulemaking on January 4, 1983. You may be assured that all concerns and comments received during the comment period, which closed March 4, will be carefully considered in the development of final regulations.

The current conditions of participation have been in effect since 1966 and do not reflect changes in the state of the art in the medical profession.

Q. Do you support the timing and rate of increase in the Medicare Part B premium?

A. Yes. Under this proposal, the yearly increase, scheduled under current law to rise in July 1983 to [illegible] per month, would be postponed to January. It would then be on the same cycle each year as the cost of living adjustments in Social Security benefits. In addition, in 1984 the premium would be set at 25% of the projected Part B outlays for the year. This percentage would then increase yearly until the premiums cover 35% of projected outlays (January 1988), and would then be held constant.

When the Part B program was first established, premiums covered 50% of projected outlays; the other half came out of general revenues. Our proposal moves the program closer to the original balance between premium financing and general revenues.

Q. What is your position regarding home health care? Would you consider developing legislative initiatives to:

a. Create incentives that will encourage health care providers to shorten patient hospital stays when appropriate by improving access to basic health care in their home;

b. Encourage the development of expanded community based home health programs;

c. Determine support services (e.g. Respiratory Therapy, Nutritional Services, Homemaker/Home Health Aide Services, Day Care, Occupational Therapy, Physical Therapy, etc.)?

A. I am aware of your interest in this initiative and we are willing to discuss any recommendations you may have.

One of the difficulties, as you know, is finding a way to target such a program to those who truly would otherwise be forced to go to a hospital [illegible] by family or friends. This would be very costly. [illegible]

[illegible]

Hatch

Q. The cost of mental illness to our society is estimated at $40 billion for 1979. In view of these costs and the GMENAC report's findings of the need for mental health professionals, can you tell me the justification of zero funding mental health clinical training programs?

A. When the NIMH clinical training program was established 34 years ago there were only 5,000 psychiatrists in the country and most medical schools did not have independent departments of psychiatry. The profession of clinical psychology was in its infancy and there was no graduate level specialty in psychiatric nursing. Social work had not developed a focus on mental health. NIMH support was instrumental in building academic mental health training departments, improving the quality of training, and greatly increasing the numbers of mental health professionals. Today there are over 30,000 psychiatrists and nearly 40,000 additional practitioners trained to address the needs of the mentally ill.

There are three times as many qualified applicants as there is space available in health profession schools, indicating that, even with decreased Federal support, health professions enrollment, including enrollment in mental health fields, will likely remain at its high [illegible]

[illegible] based on the proposition that the Federal Government [illegible], and each agency should help by initiating [illegible] an.

Hatch

Q: In supporting the prospective payment plan for Medicare payments, how do you address the problem that the difference between what Medicare pays and the hospital charges will be shifted to uncovered expenses by other payors?

A: The current Medicare payment system pays one hospital $450 for treating a patient with a cataract while it pays another hospital $2,800 to treat a similar patient, with no apparent difference in quality. There is much variability in treatment practices and, therefore, substantial hospital discretion in determining the reduction of services in order to lower costs. The proposed Medicare prospective payment system provides greater flexibility than the current retrospective cost reimbursement system for each hospital to make its own cost reduction adjustments while still offering high quality care.

For example, hospitals may choose to discontinue certain infrequently performed and costly procedures if they are provided more frequently (and thus more efficiently) at another hospital in the community. Consolidation of services of this sort would have a beneficial effect on costs. In addition, a hospital performing a higher volume of the procedure is likely to have better outcomes due to the greater experience of hospital staff and attending physicians.

Within a given hospital, administrators might question physician requests to procure more equipment and to provide services that extend beyond regional medical norms. Peer pressure should also influence those physicians with relatively costly and cost-ineffective practice patterns to modify their behavior.

It should also be noted that the proposed prospective payment system will establish strong incentives for hospitals to economize rather than spending more and shifting any unreimbursed excess to private payors. For example, hospitals that perform only a small number of certain types of complicated procedures requiring substantial overhead will have an incentive to consider whether they are efficient providers of these services. To the extent that prospective payment causes hospitals to specialize and become more efficient, all buyers of health care services-- public and private — will benefit.

Medicare does not pay for some items that are covered by some private insurers, but that doesn't mean Medicare is paying less than its fair share of costs. It is paying its share, and will continue to do so.

For instance, Medicare does not pay for telephone and televison, unsponsored research, stockholder support services, and the bad debts or malpractice costs generated by non-Medicare patients. The Department and Congress have agreed that these services do not represent allowable costs associated with the treatment of Medicare patients.

Hatch

Q: Following changes in Medicaid in FY 1982, have any States withdrawn from Early Periodic Screening, Diagnosis, and Treatment (EPSDT) programs? And what impact does this have on Head Start grantees since they are required by law to provide these medical services?

A: No States have withdrawn from the EPSDT program because it is a mandatory program and would place a State out of compliance with Federal Medicaid requirements should it fail to provide EPSDT services. The State of Arizona will have a fully implemented EPSDT program by the middle of 1983 as a result of a special waiver.

There is no impact on the Head Start program since no States have withdrawn from the EPSDT program. Presently, 40 percent of Head Start children are eligible for Medicaid. The inter-agency agreement between EPSDT and Head Start insures no overlapping of health services to those children.

Q. The budget for fiscal year 1983 eliminates all funds for clinical training in the areas of mental health, drug abuse, and alcohol abuse. At the same time, the report of the Graduate Medical Education National Advisory Committee indicates there will be a shortage of psychiatrists and other mental health care professionals over the next decade. How do you square the proposed elimination of NIMH clinical training with the Advisory Committee report?

Q. When the NIMH clinical training program was established 34 years ago there were only 5,000 psychiatrists in the country and most medical schools did not have independent departments of psychiatry. The profession of clinical psychology was in its infancy and there was no graduate level specialty in psychiatric nursing. Social work had not developed a focus on mental health. NIMH support was instrumental in building academic mental health training departments, improving the quality of training, and greatly increasing the numbers of mental health professionals. Today there are over 30,000 psychiatrists and nearly 40,000 additional practitioners trained to address the needs of the mentally ill.

There are three times as many qualified applicants as there is space available in health profession schools, indicating that, even with decreased Federal support, health professions enrollment, including enrollment in mental health fields, will likely remain at its high current level.

Our budget request is based on the proposition that the Federal Government must reduce its spending, and each agency should help by initiating program cuts where it can.

Hatch

Q. Would you consider developing legislative intiatives to ... (B) encourage the development of expanded community based home health programs....?

A: The home health services legislation recently enacted as part of the Orphan Drug bill (P.L. 97-414) authorizes a program of grants and loans for the purpose of establishing and operating home health agencies. The Department is currently exploring administrative mechanisms for the implementation of that program.

Senator Hatch

Q: Late in 1981, an infant born with a birth defect known as Down's syndrome died because the parents chose not to allow the hospital to provide the infant with the care it needed. The Department acted swiftly to remind hospitals of their obligation to provide services to handicapped patients.

It was suggested that strong regulations or guidelines regarding the care of handicapped infants be written and indeed draft guidelines were formulated. As a strong advocate of handicapped patients, programs and groups, it is my concern that these children and their rights be protected.

Would stronger regulations achieve this and what steps has the Department taken to go further than guidelines and write stronger regulations?

A: The Department issued a new regulation on March 7, 1983, that modified existing Section 504 requirements. This regulation mandates that each recipient of Federal financial assistance who provides covered health care services to infants post and keep posted in a conspicuous place in each delivery, pediatric and maternity ward, along with each nursery and intensive care nursery, a notice stating, in pertinent part, that "Discriminatory Failure to Feed and Care for Handicapped Infants in this Facility is Prohibited by Federal Law." The regulation also establishes a toll-free 24-hour hotline to facilitate the filing of complaints with the Department.

Q: Since the time of the "Infant Doe" case, has the Department received any further complaints regarding handicapped infants? If so, what is the Department doing to follow-up on them?

A: The Department has received and investigated ten (10) complaints of alleged violations of Section 504 relating to health care for handicapped infants. Case summaries of those investigations are submitted for your review.

COMPLIANCE REVIEWS

Introduction

Subsequent to the May 18, 1982 notice to health care providers, the Office for Civil Rights (OCR) developed several implementing strategies. One of these was to proactively ascertain compliance in the treatment of handicapped infants. Pursuant to this strategy, compliance reviews were initiated in four of the major teaching hospitals; namely, Yale-New Haven Hospital, Stanford University Medical Center, University of South Alabama Hospital and Clinic, and University of New Mexico Hospital/Bernadillo County Medical Center. A summary of each compliance review follows.

Yale-New Haven Hospital

In July 1982, the OCR regional office in Boston initiated a compliance review of Yale-New Haven Hospital to examine the hospital's practices and procedures for handling newborn infants with congenital malformations. OCR requested medical records relating to all neonatal deaths at Yale-New Haven Hospital during the periods of January through June of 1981 and March through April of 1982. More than 100 records have been reviewed, and further reviews are scheduled for early March, 1983.

On October 12, 1982, OCR received a complaint from the Department of Justice that was filed with that Department in June 1982, by State Senator Regina R. Smith of the Twelfth Senate District in North Branford, Connecticut alleging that Yale-New Haven Hospital engaged in a pattern and practice of denying medical treatment to handicapped infants. Since OCR was already investigating this issue, the complaint was included in the compliance review.

Hospital personnel have been interviewed, as has Senator Smith. The review has also included consultations with State officials involved in a prior review at Yale-New Haven and an examination of information obtained in State legislative hearings.

University of South Alabama Hospital and Clinic

Two onsite visits were made to this facility during the periods August 31 to September 3, 1982, and January 19 to 21, 1983. Hospital personnel have been interviewed and medical records of infants born with one or more of the five congenital anomalies (Downs Syndrome, Turner Syndrome, Deletion Syndromes, meningomyelocele and hydrocephalus) were identified and reviewed. The compliance review is near completion.

University of New Mexico Hospital/Bernalillo County Medical Center

An onsite visit was made to this facility during the period of September 13 to 17, 1982. During this onsite, medical records of newborns born with one or more of the five congenital anomalies for the period August 1981 to July 1982 were identified and reviewed by a medical expert. Hospital personnel have been interviewed. The compliance review is continuing.

Stanford University Medical Center

Two onsite visits were made to this facility during the periods August 23 to 27, 1982, and January 17 and 18, 1983. During the initial visit, access to medical records was delayed. After a number of discussions between the HHS Office of General Counsel and the attorney for the university, access was made available to review the medical records of infants born with one or more of the 34 congenital anomalies from June 1, 1981 to May 3, 1982 (12-14 records). On January 17 and 18, 1983, OCR returned to the facility to review 28 additional records.

OCR is now analyzing the evaluations provided by the OCR medical consultant.

CRAWFORD MEMORIAL HOSPITAL

Robinson, Illinois

Allegation

On May 14, 1982, the Office for Civil Rights (OCR) received a complaint from an advocacy group official who, responding to an anonymous call, alleged that:

1. Crawford Memorial Hospital (at the parents' request) failed to perform necessary surgery on an infant born with myelomeningocele (spina bifida);
2. The parents did not want the child to live; and
3. The hospital was permitting death to occur.

Investigative Response

On May 15, 1982 (through May 20, 1982), an OCR investigator conducted an onsite investigation. The investigator interviewed all pertinent hospital officials and personnel at the Illinois Department of Children and Family Services (IDCFS) who had conducted an investigation into this case.

Investigative Findings

The investigation revealed that:

1. Baby Doe was born on April 30, 1982, at St. John's Hospital in Springfield, Illinois. The baby was transferred to Crawford Memorial Hospital on May 1, 1982.
2. Baby Doe was initially diagnosed as having mila myelomeningocele (spina bifida).
3. There is no evidence which would support that the recommendation for surgery, during the infant's hospitalization at Crawford Memorial Hospital, required emergency procedures.
4. The parents, independently, made the decision to remove the baby from St. John's Hospital against medical advice, and had the baby transferred to Crawford Memorial Hospital. St. John's Hospital recommended and was prepared to perform surgery on the baby.

5. St. John's Hospital discharged the baby against medical advice. IDCFS' May 11, 1982, "Unusual Incident Report" reflects statements that two St. John's physicians concurred that it was the parents' choice to decline surgery and that they did not feel the parents were medically neglecting the child.

6. Medical records and allied documents clearly state that the parents were counselled regarding the pros and cons of surgery to enable them to make an informed decision. There was some indication that the risk of surgery was greater during the earlier hospitalization at St. John's Hospital.

7. Medical records and medical authorities agree that the baby's condition improved during the stay at Crawford Memorial Hospital though the recommendation for surgery (nonemergent) remained in effect.

8. The treatment provided was within the bounds of reasonable medical judgment and does not reflect a discriminatory withholding of life sustaining treatment on the basis of handicap.

9. IDCFS conducted a prompt investigation of this infant's situation and determined there were no grounds for filing a petition of neglect and abuse with the Crawford County State's Attorney. On this basis, IDCFS did not take custody of the baby until the parents voluntarily relinquished their parental rights to IDCFS.

10. The Crawford County State's Attorney discussed the situation with the IDCFS investigator and determined that he had no basis for taking any further action against the parents or the Crawford Memorial Hospital unless the situation changed.

Conclusion

Based on the investigative findings, there is insufficient evidence for OCR to conclude that there was a violation of Section 504.

CITY OF HOPE NATIONAL MEDICAL CENTER

Duarte, California

Allegation

On January 10, 1983, a complaint was filed alleging that the City of Hope Medical Center denied the complainant's son admission to the Center for a bone marrow transplant solely because of his handicapping condition, Downs syndrome. The complainant applied for admission to the City of Hope on two occasions--July and October, 1982. At the time of the complainant's requests for admission, his leukemia was in remission and the hospital had a bed available. At the time the complainant filed, his leukemia was out of remission and this made a bone marrow transplant impossible.

Investigative Response

OCR has initiated an investigation of this complaint. The hospital has been asked for all pertinent information concerning the circumstances of this case.

LANSING GENERAL HOSPITAL

Lansing, Michigan

Allegation

On January 24, 1983, the Office for Civil Rights (OCR), Washington, D.C., received a telegram from an official of an advocacy group alleging that a Detroit newspaper reported on January 21, 1983, that there had been an attempt to withhold treatment of a handicapped newborn at Lansing General Hospital, Lansing, Michigan. A copy of the news article was attached. The official requested that OCR conduct an investigation into this matter.

The news article indicated that a deformed baby born to a surrogate mother was treated for a streptococci infection over the objections of the father who had told the hospital not to care for the child. The news article further indicated that based on a suit filed by the hospital, an Ingham County Circuit judge issued a temporary order allowing the hospital to conduct tests and treat the baby. The hospital had alleged in the suit that the father had told the hospital and doctors not to "take steps or measures to treat the strep infection or to otherwise care for" the baby. The news article indicated that the child remained in the hospital, but gave no indication regarding the baby's condition.

Investigative Response

On January 24, 1983, an OCR investigator contacted the Ingham County Department of Social Services, the county agency responsible for child protection services. The investigator was informed that the baby had been discharged from the hospital on January 22, 1983, placed under their custody, and might be placed in a foster home.

The investigator contacted the hospital administrator regarding the baby's condition and the clerk of the Ingham County Circuit Court to obtain copies copies of the all documents associated with the suit filed January 11, 1983, by the Lansing General Hospital.

Investigative Finding

The OCR investigation revealed that:

1. The infant was diagnosed as having microcephalism, a genetic anomaly resulting in skull development of abnormally small dimensions and frequently associated with mental retardation. The infant also had a Group B Streptococci infection, endangering the infant's life if untreated.

2. The hospital took immediate steps to obtain an appropriate court order to assure that needed treatment was provided, notwithstanding objections from the father.

Conclusion

Based on the investigative findings, there is no evidence of a violation of Section 504 by the hospital.

[illegible]

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[illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. Following stabilization, the child was discharged on [illegible]. Parents were provided with equipment and training to provide special care for the infant who continued to suffer from several incurable conditions.

5. The evidence indicated that the hospital provided all proper treatment.

6. The State Department of Public Welfare conducted an investigation [illegible] and concluded there was no evidence of medical neglect.

Conclusion

Based on the investigation findings, there was no evidence of a violation of Section 504 in this case.

[illegible] FRANCIS HOSPITAL

[illegible]lsa, Oklahoma

[illegible]

[illegible]l of an advocacy group filed a complaint
[illegible]me student nurse at St. Francis Hospital
[illegible]t nurse alleged that a baby was not receiving
[illegible]s being being deliberately dehydrated, and
[illegible]ial care.

[illegible]

[illegible]estigator from Region VI (Dallas, Texas)
[illegible]. Francis Hospital. Interviews were
[illegible]ls. A Public Health Service physician
[illegible]rds.

[illegible]

[illegible]:

[illegible]ember 10, 1982, with initial
[illegible]ty Hydrocephalus.

[illegible]ater diagnosed as Hydranencephaly
[illegible]mplete absence of cerebral
[illegible]position of the Great Vessels
[illegible]als into heart). Life expectency
[illegible]ital anomalies such as this is very
[illegible](50%) die within the first 48 hours
[illegible]in six months. The remainder, if
[illegible]ar.

[illegible]rovided quality care to the infant.
[illegible] appropriate diagnostic tests and
[illegible]hat the baby received the proper
[illegible]propriate supportive services which
[illegible]n all decisionmaking processes
[illegible]nd ensured that the infant's
[illegible]vided for his nursing care. The
[illegible]ll possible treatment.

[illegible]its policy and procedures as relate to
[illegible] applies to critically ill infants.
[illegible]ted to the Eastern Oklahoma Perinatal
[illegible]ately placed on the critical list.
[illegible]dication were immediately initiated.

5. The records show that from the beginning the infant was incapable of feeding due to the lack of sucking reflexes. The feeding was conducted by the nurses in the EOPC by gavage feedings, that is, insertion of a tube down the esophagus to the stomach. This procedure was performed during every feeding. The amount of formula given to the infant was in accordance with guidelines established by the Academy of Pediatricians.

6. The remainder of the medical records show that the infant continued to gain weight and grow. The nutrition notes reveal that as the infant grew, there was a corresponding increase in the formula given. Any and all medications, observations, ancilliary services and care given was properly documented.

Conclusion

Based on the investigative findings, OCR concluded there was no evidence of a violation of Section 504 in this case.

BRACKENRIDGE HOSPITAL

Austin, Texas

Allegation

On January 17, 1983, OCR received a complaint that Brackenridge Hospital in Austin, Texas is practicing infanticide against newborn babies with serious birth defects. The complaint was made by a woman who gave birth to twin boys at the facility in July, 1979. The babies were premature, and suffered from various life-threatening conditions, including respiratory distress syndrome. One of the twins died three days after birth. The parents were not satisfied that either child received appropriate care. Since 1979, the parents have sought redress by bringing their complaints against the hospital to the attention of various agencies and officials. The available information indicates that they are presently associated with various advocacy groups in putting forth their claims. The complainant alleged that the facility in question allows newborn babies with serious birth defects to die pursuant to a medical staff policy designed to save the hospital the high cost of treating such babies in the neonatal intensive care unit. It was further alleged that the facility failed to use life-saving measures and/or used life-threatening measures while providing care to handicapped newborns.

Investigative Response

On January 17, 1983, OCR contacted the complainant by telephone to obtain additional information. It was found that the complainant was not alleging that at the present time (i.e., on January 17, 1983) any particular child who was then a patient at the hospital was being denied treatment for a life-threatening condition. On January 27 and January 28, 1983, an OCR investigator and a consulting physician conducted an on-site investigation at the hospital.

Investigative Findings (Interim)

The OCR investigator and physician reviewed records of infants born during the period July 1, 1982 - December 31, 1982 with any of numerous abnormalities. The physician specified that his review of the records was made to determine whether infants with handicapping conditions were treated in accordance with generally accepted standards of newborn care; denied life-sustaining measures which would be generally expected to be rendered under similar circumstances; and/or treated by means which might reasonably be anticipated to hasten demise. The physician found that:

1. Appropriate therapeutic modalities were not withheld from these patients.
2. No actions had been taken to speed death; and
3. In all cases, the procedures followed were routine for such a neonatal intensive care unit.

Conclusion

The investigation is not yet completed.

UNIVERSITY OF WISCONSIN HOSPITAL

Madison, Wisconsin

Allegation

On May 7, 1982, the Office for Civil Rights (OCR) received a complaint from an advocacy group alleging that two infants who were survivors of abortions at the University of Wisconsin Hospital had died. The complainant (who was later joined by other advocacy groups) requested that OCR investigate the infant deaths to determine whether any medical treatment was discriminatorily denied. The complaint was based on newspaper articles concerning the abortions.

Investigative Response

OCR conducted an onsite investigation into this complaint. Interviews were conducted with hospital officials, the coroner, and with the Dave County district attorney.

Investigative Findings

The OCR investigation revealed that:

1. On May 4, 1982, two girl babies were born live following abortion procedures. They were transferred to Madison General Hospital's Obstetric ICU where they subsequently died on May 5 and 6, respectively.

2. The hospital's general policy precludes abortions where the fetus is more than 23 weeks old. Following the births, these babies were estimated to be 26 and 22 weeks old.

3. During the 1970s, the hospital's OB department was transferred to Madison General Hospital. University-based physicians and teaching faculty serve both facilities.

4. The University hospital has a pediatric ICU; Madison General is a designated high risk neo-natal center and has an OB ICU. Both are tertiary care facilities.

5. Hospital physicians stated that all normal pre-abortion lab tests had been accomplished and the fetuses were determined to be less than 23 weeks old. Nursing staff completed the required counseling of the mothers and said that their standard consent forms were signed by the mothers. In accordance with law, all results were reported to the Center for Disease Control.

6. In both cases, it is documented that life-saving procedures were applied following these live births. The University hospital applied resuscitation and other procedures within their pediatric ICU; then, effected transfer to the Madison General Hospital OB ICU, which is the designated high risk neo-natal center.

7. Reportedly, both mothers signed the prescribed consent forms which require the hospital to attempt to preserve the life of the fetus in such instances.

8. Based on the coroner's report and the investigation conducted by the District Attorney, "there is no criminal law which even possibly could have been violated in these cases."

Conclusion

Based on the investigative findings, there is no evidence of a violation of Section 504.

GOOD SHEPHERD HOSPITAL

Barrington, Illinois

Allegation

On September 17, 1982, an official of an advocacy group filed a complaint with the Office for Civil Rights (OCR), alleging that a multi-handicapped infant was in a life-threatening situation at Good Shepherd Hospital and requested OCR intervention.

Investigative Response

On September 17, 1982, an OCR investigator initiated an onsite investigation. The assistant administrator, attending physician and the assistant director of nursing/head of obstetrics, were immediately interviewed. Officials of the Illinois Department of Children and Family Services were also contacted; they initiated their own investigation. While the OCR investigator was onsite, the infant was transferred to Children's Memorial Hospital in Chicago for further evaluation.

Investigative Findings

1. The baby was born on September 14, 1982 by Caesarean Section.
2. At the time of delivery, there were multiple anomalies noted, particularly arrhinencephaly, marked hydrocephalus, micro-ophthalmia, cleft palate and midline defects, multiple skeletal anomalies including deformed hands, and abnormal location of extra digits.
3. Attempts were made to feed the infant, but the infant had no capacity for sucking.
4. The parents signed every possible consent form for treatment.
5. On September 18, 1982, at 12:03 a.m., the infant was officially pronounced dead.
6. An HHS Public Health Service physician, after review of all medical records and the autopsy report, concluded that given the nature and severity of the problems, there were no procedures or services which could have been provided which might have changed or otherwise influenced the outcome.

Conclusion

Based on the investigative findings, OCR concluded there is no evidence of a violation of Section 504.

Senator Stafford

Question: The President's budget of $24.6 million is a 43 percent cut in the Developmental Disabilities State Grant Program. Do you feel that with the magnitude of this cut that persons with developmental disabilities will be adquately served?

Answer: Yes, we believe that the funding we have requested is adequate to maintain this program. The reduction is proposed in the basic state grant program where projects have been funded for the last decade to stimulate and demonstrate service projects. Support for many of these projects can be provided by the member agencies of the State Developmental Disabilities Councils or through the funds provided to States through the SSBG.

We would also point out that we have asked for only very minor reductions in funding (from $7,320,000 in FY 1983 to $7,302,601 in FY 1984) of the Protection and Advocacy Grant Program. The establishment of a Protection and Advocacy System is a requirement for participation in the basic state grant program. This support recognizes the importance of Protection and Advocacy systems in assuring that services are provided to the developmentally disabled population.

Q: In light of recent Administration actions affecting the Title X family planning program, there has been considerable public interest in your position on family planning. Am I correct in my impression that you support the Title X program and view it as a basic preventive health program?

A: I definitely support the Title X family planning program. The Administration views family planning as a fundamental human and health concern. I am committed to assuring the best possible family planning services for those in need.

Stafford

Q. Just a few days before former Secretary Schweiker announced his resignation, he ordered that the Office for Family Planning be moved from the Bureau of Health Care Delivery and Assistance and placed in the Office of the Assistant Secretary for Health. This is the first time in the program's 12 year history that it has been isolated from other established health service delivery programs and taken out of the hands of career public health professionals to be administered by a political appointee. Since the program has been effectively administered in the past, in accordance with Congressional intent, and since former Secretary Schweiker assured me and other Members of Congress last summer that "this program should be located in the Bureau of Health Care Delivery and Assistance," perhaps you can explain the rationale for this move?

A. As you indicated, Secretary Schweiker had initially determined to place the Office for Family Planning in the newly created Bureau of Health Care Delivery and Assistance. However, for the following reasons, he decided to reconsider that decision and proceed with the reorganization on January 7, 1983.

The purpose of the reorganization is to bring two closely related programs, family planning and adolescent family life, under a single program manager, the Deputy Assistant Secretary for Population Affairs (DASPA). It also eliminates the split between the setting of overall policy in family planning and the operations which implement the policy. The reorganization places the DASPA in charge of operations as well as policy oversight, thereby bringing the organizational arrangement into conformance with statutory provisions regarding the DASPA's responsibility for administering family planning. As noted by Senator Denton at the hearing, P.L. 91-572, which created the Title X programs, and a 1978 House Select Committee on Population report, respectively, mandate and support this reorganization.

We have no plans to make changes in the function of the programs. Career public health professionals will continue to carry out the tasks of the office. I should mention, also, that the DASPA has always been a political appointee.

Stafford

Q: Under the reorganization, will the role of the DHHS regional offices in making grants for family planning services be changed? If so, how?

A: Regional activities of the family planning program will continue without interruption. The Regional Health Administrators will continue to be the immediate supervisors of the regional family planning staff.

Q: If there is good reason to believe that the move of the Office for Family Planning is detrimental to the goals of the family planning program and not in the best interests of those who depend on its services, would you consider returning the program to the Bureau of Health Care Delivery and Assistance?

A: We believe that the transfer of the Office of Family Planning will lead to better and more efficient program management and will serve the best interests of those who receive Title X services. We have no plans to make changes in the function of the programs and expect no changes in the funding of the program as a result of this reorganization. Our mission will be to make the Title X program work in the Office of Population Affairs.

Senator Quayle

Q: The proposed revisions of these hospital conditions of participation regulations were published in the Federal Register on January 4th and are awaiting evaluation of public comment, and indeed, the proposal does call for the deletion of the section relative to social work services.

Given your previous statements on this issue, do you still maintain your opposition to the deletion of social work services in the conditions of participation?

A: I would like to emphasize first of all that hospitals have never been required to have a department of social services and that these services will continue to be a reimbursable cost under Medicare, regardless of the changes proposed in these regulations.

The old rules dictated extensive standards, including costly staffing requirements, and this is what we have proposed to eliminate. Expensive and rigid requirements can actually discourage the smaller hospitals from offering social services.

The 60-day comment period closed on March 7. You can be assured that this issue, along with the other comments received, will be carefully considered in the development of the final regulations.

Quayle

Q: Two years ago, the Department of Health and Human Services was asked to review the regulations relating to Medicaid prescription reimbursements. Various organizations involved in the drug industry have tried unsuccessfully to meet the Secretary to discuss this issue.

The regulations in question require that states pay pharmacies the lower of either the pharmacy's "usual and customary" charge to the public, or the acquisition cost of the drug plus the dispensing fee. These regulations were based on costs established in the 1960's and have not been updated since. As a result, the losses pharmacists sustain from dispensing high cost Medicaid prescriptions are passed along to the general public in the form of price increases, or, in some cases, not dispensed to the beneficiaries.

Would you look into this matter, and, at the very least, set up a meeting with the industry representatives, to discuss the problem with them?

A: It is my understanding that former Secretary Schweiker met with concerned organizations to discuss Federal reimbursement under Medicare and Medicaid for certain drugs. Specifically, last August he held discussions with the National Wholesale Druggists Association concerning the utility of the Maximum Allowable Cost program.

As Secretary of Health and Human Services, I will be happy to continue to work with organizations having an interest in this issue to discuss our policies in this area.

Q: What is the precise target for publication of the End Stage Renal Disease (ESRD) payment regulations?

A: As you know, since my appearance before your committee, I have been confirmed as Secretary. Subsequently, I signed the proposed ESRD regulations on March 23, 1983.

Senator Weicker

Q: The proposed revisions of these hospital conditions of participation regulations were published in the Federal Register on January 4th and are awaiting evaluation of public comment, and indeed, the proposal does call for the deletion of the section relative to social work services.

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The 60-day comment period closed on March 7. You can be assured that this issue, along with the other comments received, will be carefully considered in the development of the final regulations.

Q: In December, draft guidelines for the Title X Family Planning Program were circulated within DHHS. These guidelines required family planning clinics that also provide abortion services -- the latter financed entirely with non-federal funds -- to have totally separate staffs, equipment, space, etc. In order to avoid "even the appearance of federal funding for abortion activities". Given that the GAO and DHHS Inspector General have recently produced reports exonerating Title X clinics of any violations of the law with regard to abortion or lobbying activities, do you think these guidelines are necessary and appropriate?

A: The General Accounting Office, in its September 24, 1982 report entitled "Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification", recommended that the Department "set forth clear guidance on the scope of abortion restrictions in its Title X program regulations and guidelines." The Department agreed to provide this guidance. A first working draft was prepared at the Bureau level to generate discussion of the various aspects of this issue. This draft has not been approved at a higher level. We are continuing to work on developing appropriate clarification in response to the GAO recommendations.

Senator East

Q: You have recently indicated that, as a member of the Reagan administration, you would enforce regulations that require federally funded family planning clinics to notify parents of minor children to whom they dispense prescription control drugs and devices.

a. In view of your present position, would you also support a regulation that would require prior parental consent or notification before a federally funded organization referred a minor child for surgery, including abortion?

b. If not, why should federal funds be used to refer minor children for surgery such as abortion without any parental involvement but be required to notify parents about the use of prescription birth control drugs or devices?

c. Do you think it fair for taxpayers' funds to be used to aid and abet an action for which federal funds are prohibited?

d. Would you support a regulation prohibiting the use of DHHS funds for referring patients from DHHS-supported grantees to clinics that perform abortions?

A: The parental notification regulations implement a 1981 amendment to Title X which requires projects supported by Title X to encourage, to the extent practical, family participation in the provision of project services. The Department believes that the parental notification regulations are authorized by the statute and are consistent with the clear intent of Congress. In fact, as you know, any agency regulation must have a statutory basis and must reflect the will of Congress. It is in light of this obligation that the Department is examining the need for any further regulations, including those about which you asked. Similarly, federal funds will not be expended for activities which are prohibited by Federal statute.

Senator Hawkins

Q: Can you assure me that childhood immunization programs will continue to receive top priority in PHS funding decisions?

A: Yes. The childhood immunization program has been one of the most successful and cost-effective preventive health programs in which the Federal Government has participated. The Department has long placed high priority on protecting our Nation's children against the vaccine-preventable diseases, with special emphasis in the last few years. Immunization coverage has increased to the highest levels ever, and reported cases of disease have dropped to record low numbers. We continue to place high priority on the childhood immunization program, as indicated by our 1984 budget request and our long-range disease prevention objectives for 1990.

Q: Can you assure me that the Department will continue to cooperate with this Committee and that this productive, constructive relationship will continue?

A: Yes. Protecting our Nation's children against the vaccine-preventable diseases continues to be of high priority in the Department of Health and Human Services, and we appreciate the interest which you and this Committee have taken in it. The Interagency Group to Monitor Vaccine Development, Production, and Usage will continue to coordinate studies and investigations to develop a safe, reliable pertussis vaccine. The Department also will continue to conduct studies and investigations to determine the safety and efficacy of presently used and new vaccines.

Senator Hawkins

Q: Would you take a careful look at the need for funding tuberculosis control through categorical project grants instead of relying on the Preventive Health Block Grant?

A: Congress appropriated $1 million for Fiscal Year 1982 and $5 million for Fiscal Year 1983 for categorical tuberculosis project grants. These resources are being used in highly impacted States and communities to assist them in addressing their tuberculosis problems.

During the budget process, the Department carefully considered options for providing tuberculosis assistance to States and localities. Options included the Preventive Health and Health Services Block Grant as well as categorical tuberculosis project grants.

We believe that the Preventive Health and Health Services Block Grant is the best alternative for funding tuberculosis control activities. since it is a flexible funding mechanism by the States. This approach is consistent with the Administration's objective of consolidating categorical health programs into block grants to be used according to individual States' priorities.

Senator Kennedy

Question: I understand that the allotments for Fiscal Year 1983 (for the Runaway Youth program) have not yet been distributed. Can you tell us what the Department's timetable is for making this money available?

Answer: We published our Runaway Youth program funding announcement in the Federal Register on March 17, 1983. This is about the same schedule that we follow each year (the funding cycle normally starts in the early spring). We plan to obligate all the funds appropriated by the Congress for this program by the end of the Fiscal Year.

Question: What is the status of the Department's efforts to deal with domestic violence? Given the increased demand for services to victims of family violence that is related to the tragic unemployment situation, do you believe increased efforts by the Department in this area are needed?

Answer: The Department does not provide services funds directly to projects for adult domestic violence. As you know, the child abuse statute does not provide authorization for support of projects designed to address violence between adults. We have, however, supported a series of demonstration projects on services to children in shelters for battered women.

In addition, the Social Services Block Grant under Title XX of the Social Security Act provides authority for a wide range of services, including protective services for children and adults. The flexibility of the Social Services Block Grant allows the States to determine whether increased funds should be directed to particular kinds of services, including domestic violence.

Senator Kennedy

Question: In the past, you supported Federal legislation in this area (domestic violence). I am introducing Congresswoman Mikulski's bill in the Senate and have Republican as well as Democratic cosponsors.

Will you support this initiative as you have in the past? Can we count on you to get the President and the Administration behind this effort?

Answer: I would like to review any new legislative proposal before giving you a specific answer, but in general I would say that this Administration does not support the creation of new Federal categorical programs as the primary approach to dealing with domestic social services problems.

As I mentioned in the previous question, the Social Services Block Grant funds can be used to address this issue. Rather than mandate specific funding from the Federal level, the block grant allows each State to decide its priorities and to allocate its funds accordingly.

In addition, under the New Federalism proposal recently sent to the Congress by the President, the proposed State Fiscal Assistance Block Grant would provide even greater flexibility among programs, including the Social Services Block Grant and the Maternal and Child Health Block Grant.

Q. Twenty-two States have established workfare programs. What evidence do we have that these programs are working?

A. Although many States have not been operating their workfare programs for long periods of time, there is preliminary evidence suggesting that workfare works and that support for the program exists in many sectors of society. This increased support for the program was noted in the October 28 Wall Street Journal which found growing acceptance from both academicians and program officials.

States are becoming increasingly supportive. More States are planning to implement programs this year, and other States are expanding the scope of their existing programs. Previously skeptical State work program staff have indicated that they feel very positive about the program now that they have had an opportunity to observe its benefits. For example, they have indicated that they have seen notable improvements in the attitude and appearance of CWEP participants.

Participants are also demonstrating substantial support for the programs --both directly (through press interviews) and indirectly (through their high rate of voluntary participation).

O. What difference have these programs made in either lowering welfare costs or making welfare recipients more employable?

A. Four States (Oklahoma, New York, North Carolina, and West Virginia) have reported that 20-30 percent of their CWEP participants are entering employment.

In several States where the State welfare agency has implemented strong, comprehensive work programs, placements in regular employment are running substantially above the levels achieved by WIN.

Michigan is reporting about 2,000 placements a month (twice the rate under WIN)—in spite of unemployment rates in the vicinity of 17 percent.

Oklahoma is reporting placements 200 percent above the level previously reported under WIN.

New York State reported that the entered employment rate for CWEP participants was running about 60 percent above the rate for WIN registrants.

We believe that making welfare recipients more employable will be a major factor in the lowering of welfare costs. Other factors include deterrence of individuals who have come to view welfare as an alternative to work and sanctions of individuals who refuse to cooperate. Although deterrence is very difficult to measure, New York estimated that its CWEP requirements were deterring about 9 percent of the potential participants. New York and North Carolina reported sanction rates in the range of 10 to 15 percent, but sanction rates varied considerably from State to State.

Costs of the program appear to be manageable. Several States are reporting that costs are running in the range of $20 to $40 per participant per month. In terms of program savings, New York State estimated that savings to the welfare program exceeded the costs of operating CWEP by a ratio of about 2 to 1.

Q. Are you familiar with a study GAO released on January 24th in answering the question "Does AFDC workfare work?"

A. Yes, we are familiar with that study.

Q. The report states the HHS evaluation program has not yet produced information that can show whether workfare "works." In fact, no data are available and GAO thinks little will be available.

A. GAO misrepresents our CWEP demonstration program. The primary purpose of our demonstration projects is to develop model approaches and designs for CWEP projects--not to evaluate the CWEP's effectiveness. Nevertheless, several of the demonstration States are reporting statistical data to us on a regular basis which can be used in future assessments of the CWEP.

We are not totally dependent upon the CWEP demonstration projects for data on program effectiveness. CWEP States which are not part of the demonstration program also develop statistical information and share their findings with us.

O. Why should we consider extending this program to all the States before we know whether "workfare works"?

A. We have already received preliminary information on the CWEP from several of the States with operational programs. This information which I discussed in an earlier response, has strengthened our belief in the effectiveness of "workfare" as a means of improving employability for AFDC recipients and of reducing welfare dependency. Our initial belief in workfare was based on results which were achieved by earlier work experience programs, for example, in Utah's WEAT program, 35 percent of the participants had the cases closed or grants reduced as the result of employment.

O. What steps will you take to insure that Congress has this information?

A. I included much of the information we have gathered to date in my testimony and in my response to your questions. As more information becomes available, such information will be provided during future legislative hearings and in responses to future Congressional inquiries.

My staff is continually monitoring information provided by the States on the operation of their work programs and updating their information so that we can be responsive to future inquires.

Senator Kennedy

Question: Would you characterize a 63 percent cut in funding for child abuse as a freeze?

Answer: In the child abuse program, we have asked for level funding for grants to the States. That is, we have requested $6.72 million, which is the same level of funding as in FY 1983.

We have asked for a reduction in funding for research and demonstration from a total of $22 million for child abuse, child welfare, adoption opportunities and social services research and demonstration to $9.2 million for these discretionary accounts. This is consistent with the Administration policy of targeting resources to direct service activities and reducing non-service activities.

In addition, although in the State of the Union message the President stated that he would "recommend a Federal spending freeze," he also added that: "Taken as a whole, the budget I am proposing for the next fiscal year will increase no more than the rate of inflation - in other words, the Federal government will hold the line on real spending."

In order to hold the increase in Federal spending as a whole to no more than the rate of inflation, the non-entitlement programs must be reduced.

Q. -- what about eliminating legal services and the WIN program? Is that a freeze?

A. Since the Legal Services Program is not administered by the Department of Health and Human Services, I cannot speak to that program. With regard to the WIN program, we are proposing that it be replaced by a comprehensive alternative work program which is superior to WIN in several ways.

For example:

-- it requires active participation in work activities rather than merely paper registration.

- o In 1980, about half of the WIN registrants were not assigned to any active program components.
- o Many other able-bodied recipients were not ever required to register for work activities because of remoteness from WIN sites. GAO estimated that about 20 percent of the adult AFDC population would be exempt due to remoteness in FY 82.

-- it requires participation of all able-bodied applicants and recipients, not just "creaming" of those with greatest employment potential.

-- it focuses Federal and State resources on the most effective work activities (job search and CWEP).

- o Under the WIN program, one-third of the funds had to be spent on on-the-job training and public service employment.

WIN's effectiveness in reducing welfare grants was exaggerated. According to a recent GAO study the WIN welfare grant reduction calculation overstated savings by about 50 percent. Among the flaws cited by GAO were... :

1) Double-counting of individuals who accepted more than one job in the course of the year.
2) The assumption that all individuals in jobs after 30 days remained in those jobs

Also, the WIN program focused on individuals with the greatest employment potential. Those assigned by WIN tended to be at the prime working age, to be more highly educated, and more experienced.

- GAO found no statistically significant relationship between participation in WIN training activities and employment entries.

-- it would actually reduce Federal requirements on the operation of State programs (The WIN handbook is 500 pages long).

-- it eliminates the problems and inefficiencies of dual agency administration.

-- Under the Job Training Partnership Act (JTPA) will enhance the training opportunities provided to AFDC clients through the Department of Labor. Because JTPA created more specific requirements and incentives for serving welfare recipients, we no longer need separate training authorities and funds within the AFDC program. For FY 1984 the Administration is proposing $1.9 billion for training of disadvantaged populations under Title II of the JTPA.

-- States are also given Social Services Block Grants which can cover support services needed by AFDC clients in order to accept employment or participate in work activities.

Q. We know you weren't in the meeting with the President and David Stockman when these decisions were made? But what about next year's budget?

-- would you recommend cutting back on funds to prevent child abuse?

-- would you support cuts in fuel assistance?

-- what about cutbacks in programs for older Americans?

The Administration has not yet begun to make decisions on next year's budget, so I cannot comment on any specific program at this time. I would point out, however, that the Low Income Home Energy Assistance and the Child Abuse State Grant Programs are among the 43 programs recommended for inclusion in a State Fiscal Assistance Trust Fund under the President's Federalism initiative. Under the proposal, States have the option to draw on a Federal trust fund to finance State programs that have been administered at the Federal level. They will have great flexibility to target their funding. For low income home energy assistance, for instance, States could spend less in a warmer year and shift remaining LIHEAP funds to areas of greater need. In a colder winter year as demand for energy assistance increased, States could utilize more funds as appropriate. Ultimately, States would decide the amount from their trust fund which they would use for each program.

Kennedy

Q: Could you support an all-payors system of hospital cost containment?

A: No. I do not consider it an appropriate Federal role to require an all-payor system. We have established a prospective payment plan for Medicare, a Federal program. Private insurors should have an incentive to contain their costs. States are responsible for the regulation of the insurance industry.

In my opinion, the role of Federal government is to encourage -- not mandate -- the private sector to take the steps we are taking and to use other approaches of their own design to control costs.

Q: The new DRG proposal would permit hospitals to pass through construction, depreciation and interest costs. Won't this encourage excess contruction and ultimately increase costs, or does the Administration plan to submit new legislation to limit unnecessary hospital costs?

A: We understand that the capital pass-through is not an ideal solution. We propose it now as a temporary measure to allow for the development of a prospective payment method that could be phased in and applied in an equitable fashion.

Over the long term, the pass-through provides inappropriate incentives for hospitals to try to shift costs out of their operating budget and into their capital budget to the extent feasible and to substitute capital for labor where possible. There would be no incentive for hospitals to shop around for the lowest cost financing for their capital projects. We believe that the capital-cost issue needs to be addressed. We are exploring ways to deal with it and are open to suggestions on this point.

Kennedy

Q: Are you concerned that the DRG system will encourage some hospitals to alter their case mix and not admit sicker, costlier patients, thus adding to the financial burdens of public, urban hospitals?

A: We do not anticipate that our proposed system will create an incentive for hospitals to "skim" for healthier patients.

First of all, because significant medical complications are accounted for in the DRGs, the relative difference in the health of patients whose cases fall into a particular DRG should be minimal.

In addition, we will be monitoring changes in hospital admission patterns and will investigate unusual changes in the volume or patterns of admissions.

Q: Does the Department support continuing the existing State cost containment waivers, extending those waivers when they expire, and would you grant any additional State waivers under any conditions?

A: Our proposal gives the Secretary the authority to continue to develop, carry out, or maintain Medicare experiments and demonstration projects testing State alternative reimbursement approaches. As indicated in a statement in the October 8, 1982, Federal Register, we are interested in competition, capitation, DRG systems and other innovative approaches.

As for current programs approved under our waiver authority, they will each be reviewed at the time they expire, in terms of their effectiveness and their compatibility with a national system.

As you are aware, the Tax Equity and Fiscal Responsibility Act of 1982 authorizes the Secretary to pay hospitals under a hospital control system if the State program meets certain criteria. We have proposed repeal of this authority in our bill.

Kennedy

Q: Now the Administration proposes increasing copayments, premiums and deductibles that will cost the elderly and disabled nearly $17 billion over the next five years. Is the Administration's strategy an attempt to reduce the deficit at the expense of Medicare beneficiaries? How high are we willing to let out-of-pocket costs rise?

A: Patients make many of the decisions that produce health care costs, and greater cost-awareness among patients can help lead to improved efficiency in health care.

Evidence from the National Medical Care Expenditure Survey indicates that the majority of visits to physicians were initiated by patients. Moreover, as the proportion of the bill paid by the family increases, physicians are less likely to initiate visits. Thus physicians also respond to the extent of their patients' cost-sharing liability.

Our approach identifies the real problem - the backward economic incentives facing our consumers, employers, insurers, and health care providers - and addresses it. In contrast, regulation has too often been used to solve the problem of rising health care costs by imposing controls on health care providers alone, while sending the signal to everyone else that "more health care is better, and money is no object."

Medicare's cost-based system has actually rewarded inefficiency, by paying more to less efficient, higher-cost hospitals. Cost-sharing in Medicare has been backwards. Those who are less ill and could act to keep their hospital stays shorter have been given no cost incentive to do so; while severely ill patients who cannot prevent their long hospital stays have been penalized with high cost-sharing. Medicare benefits now expire altogether after a maximum 150 consecutive days, providing no coverage of catastrophic illness.

At present, the beneficiary pays:

-- First day: full cost ($350 in 1984)
-- 2nd to 60th days: no cost-sharing
-- 61st to 90th days: $87.50 per day in 1984
-- 91st to 150th days: $175 per day in 1984
-- After maximum 150 days: no coverage

This structure gives no incentive to the less ill to keep their hospital stays short - while it penalizes the severely ill.

Under the new plan, the beneficiary would pay:

-- First day: same full cost, but only twice in any year at most - compared with no limit today.

-- 2nd to 15th days: about $28 per day in 1984.
-- 16th to 60th days: about $17.50 per day in 1984.
-- After 60th day: new catastrophic coverage takes effect.

- To take two examples,

  (a) a beneficiary hospitalized for 150 consecutive days in 1984 would spend $13,475 under current law (assuming that he used his 60-day lifetime reserve) plus full cost of any additional days; under this proposal, he would spend $1,529.50 and be fully covered for any additional days.

  (b) a beneficiary hospitalized in 1984 for an average Medicare hospital length of stay (11 days for the elderly) would pay $630.

Gradual change in the premium and deductible for optical Medicare physician coverage (Part B Medicare) would be made in order to once again recover a sufficient amount of the program's costs. When Medicare was established, the premium was intended to cover 50 percent of Part B costs, but premiums now cover less than 25 percent of costs.

The Part B premium would first be frozen at the present $12.20 per month for the remainder of 1983, instead of being increased to $13.50 in July as was previously announced. The delay coincides with the delay in the cost-of-living increase for Social Security recommended by the National Commission on Social Security.

Gradual increases would be made between 1984 and 1988 to eventually recover 35 percent of annual program costs.

In addition, the Part B deductible would be adjusted annually according to the Medicare economic index to keep pace with costs. This deductible was unchanged from 1972 to 1981 despite a more than 500 percent increase in Part B benefit outlays during that period.

The copayments proposed for Medicaid are nominal -- $1 to $2 -- and are only intended to discourage unnecessary use of services. They are not so high as to discourage necessary care.

Kennedy

Q: The Administration has submitted a new proposal that claims to provide catastrophic coverage for Medicare beneficiaries. But a closer examination of the proposal makes it seem more like one of the old fly by night "medi-gap" insurance policies that Congress deplored in the late 1970s. First, it would cover only the two percent of all hospitalized beneficiaries who stay in the hospital longer than 60 days and then would cover only hospitals costs, non-physician fees and other non-covered medical expenses. Second, it would cost the average beneficiary an additional $243 per 11 day hospital stay in out-of-pocket cost, a hefty "premium" for an almost illusionary benefit. Finally, like a bad Medigap policy - it makes a big profit - the net savings to Medicare are $663 million the first year alone. Do you support this proposal?

A: Yes, but not as you describe it. First of all, there is no relationship between our proposal and the old Medigap policies that we both would deplore. Second, all would benefit by having this catastrophic coverage available should it be necessary to use it, and for those who do receive payments under catastrophic coverage, this benefit is not illusionary and is needed. Third, it is unreasonable to view this proposal in isolation from our other health incentive reforms.

Given the fast - approaching crisis over the Hospital Insurance trust fund, which without dramatic change will be exhausted by 1986, we cannot continue to follow a "business as usual" approach. When neither patients nor providers feel any pressure to thoughtfully and prudently purchase and provide health care, we have a system prone to uncontrollable inflation. We believe our incentive and reimbursement reforms will reasonably help control costs so that the Medicare program can continue to provide the benefits intended for our beneficiaries.

The practical effect:

-- Under current law, the beneficiary hospitalized in 1984 for 150 consecutive days would owe $13,475 from his or her own pocket. The beneficiary would also bear the full cost of all subsequent hospital days.

-- Under the new plan, the beneficiary's expenses would be $1,530, with no additional coinsurance after 60 days.

Some 170,000 Medicare beneficiaries each year experience a spell of illness involving more than 60 days in the hospital.

Beneficiaries today must pay the full cost of the first hospital day -- and there is no limit on the number of first-day payments that can be required in a year. Some beneficiaries make up to four first-day payments in a year.

Under the proposal, the same first-day payment is required -- but a new limit protects beneficiaries from more than two first-day payments in a year.

Under either current law or the proposal, the first-day payment will be about $350 in 1984. This represents Medicare's national average cost for a day of hospitalization. Private insurance plans also use first-day or deductible payments when they include cost-sharing.

The proposed changes in Medicare would make its coverage more fair by using moderate cost-sharing early in a spell of illness rather than imposing it heavily late in a spell of illness when the patient is likely to have little or no control over length of hospital stay.

Kennedy

Q: Can you assure us that the final regulations on hospital conditions of participation will restore the social services requirement?

A: I would like to emphasize first of all that hospitals have never been required to have a department of social services and that these services will continue to be a reimbursable cost under Medicare, regardless of the changes proposed in these regulations.

The old rules dictated extensive standards, including costly staffing requirements, and this is what we have proposed to eliminate. Expensive and rigid requirements can actually discourage the smaller hospitals from offering social services.

The 60-day comment period closed on March 7. You can be assured that this issue, along with the other comments received, will be carefully considered in the development of the final regulations.

Q. A recent Institute of Medicine report on nursing education recommended the Federal government expand its support of advanced nurse training programs because of the serious shortage of nurses with master's and doctoral degrees. Yet the Administration's budget request slashes funding for advanced training programs from $35 million to $7 million. Will the Administration amend its request in light of the IOM report?

A. The recent study on nursing by the Institute of Medicine confirmed our position that the aggregate supply of nurses is adequate and will continue to be so through 1990. Thus, there is no need for a Federal role in encouraging overall supply increases, and the 1984 budget request of $13.2 million is targeted on nurse practitioners, advanced nurse training, and nursing special projects.

Our primary objectives are to assist training institutions and hospitals to develop innovative means to address the issues of nursing utilization and distribution. However, we are requesting $1,208,000 for the Advanced Nurse Training program, which provides institutional support to collegiate schools of nursing to plan, develop and operate, or to significantly expand or maintain programs for the preparation of professional nurses at the master's or doctoral level. Nurses with advanced training provide expert or direct patient care or assume responsibility as teachers, administrators and supervisors. Special emphasis is given to clinical nursing specialties in maternal-child health, geriatrics, community health, and medical/surgical care. The requested funds will continue support for 8 projects begun in a prior year, and we have no plans to propose an increase to the budget amount for advanced nurse training.

Kennedy

Q: Last year the Administration reversed its position on legislation requiring stronger warning labels in cigarette packages. As you may recall they testified in support of the legislation in the House and one week later declined to testify in favor of the legislation in front of this Committee. What are your views on whether we should require stronger warning labels on cigarette packages.

A: I believe that stronger warning labels can be justified. Dr. Brandt, the Assistant Secretary for Health, testified on this subject on March 9, 1983 before the House Health Environment Subcommittee. I am attaching a copy of his testimony, which reflects the Department's position.

Q. Your predecessor, Dick Schweiker, frequently claimed that disease prevention and health promotion were high priorities of the Department, yet the Department proposed deep cutbacks in funds for Medicaid, Maternal and Child Health, Community Health Centers and other prevention programs. State and local officials claim infant mortality is on the rise, that lead screening programs are screening fewer and fewer children, that poor pregnant women are going without prenatal care. There is growing concern that, with the increase in vaccine prices, the Administration's request for the childhood immunization program will be inadequate. What steps do you intend to take to see that prevention programs are adequately funded and that prevention becomes a high visibility, high priority item on your agenda?

A. I will continue the high priority given to disease prevention and health promotion. The President's FY 1984 budget for the Department reflects increases in such prevention-oriented agencies as the Food and Drug Administration and the Centers for Disease Control, as well as increases in the disease prevention/health promotion programs in the Office of the Assistant Secretary for Health.

I also will assure that our 1984 budget request is sufficient to maintain our national immunization levels. In addition, our budgets for FY 1983 and 1984 include funds to initiate a stockpile of vaccines for childhood diseases to insure that production or other manufacturing problems do not interrupt the supply of vaccines to protect our nation's children.

Contrary to the thesis of some inadequately researched and erroneous statements about infant mortality, it is my sincere belief that the Administration's proposals allow a strong emphasis on prevention. Infant deaths in 1982 (there were 11.2 deaths per 1,000) were the lowest recorded in the U.S. We will not allow the health of the American people to be compromised.

Senator Randolph

Q: What are your views regarding pending legislation to permit medical professionals to administer heroin, under controlled conditions, to treat intractable pain of terminally ill persons?

A: The Administration remains committed to using proper controls and safeguards to make any drug which has unique and indisputable medical benefits available to patients. I am advised, however, that current evidence indicates that heroin offers no unique advantages over other drugs -- other pain relievers, such as dilaudid, are as effective, if not more so, than heroin.

Deficiencies in current pain therapy are related to voids in our knowledge about pain and its mechanisms, and inadequate or improper application of available knowledge. To meet this challenge, the American Medical Association, with the Public Health Service as a co-sponsor, held a Workshop on Pain in Washington, D.C., on January 28, 1983. They recommended that the medical profession improve the use of morphine and other analgesics in pain control.

We believe that heroin is not the answer. Effective pain management and increased efforts, public and private, to educate physicians and health professionals about the variety of ways severe chronic pain can be effectively controlled is the best way.

Q: It is my belief that the Interagency Agent Orange Work Group, which reports to the Council on Human Resources, is critical to focusing and coordinating Federal efforts -- particularly scientific studies -- relating to Agent Orange.

a. What are your plans to use the Agent Orange Work Group to resolve the concerns surrounding exposure to Agent Orange?

b. As you know, the Chairman of the Work Group, James Stockdale, left the Agency about one month ago. Who do you plan to appoint to this important post and when will this appointment be made?

A: The Agent Orange Working Group will continue to provide me and the Cabinet Council expert scientific advice and consultation on those complex questions relating to how to define "exposure" for the purpose of conducting an epidemiological study and to other equally difficult questions of policy and scientific method. The Agent Orange Working Group will meet as often as necessary to review the progress of the activities aimed toward measuring the health effects among Vietnam veterans due to exposure to Agent Orange.

Selecting a replacement for the chairperson of the Agent Orange Working Group is a priority. I will advise the Committee of the selection as soon as possible.

Senator Randolph

Q: What is your position on creating a new national institute for arthritis?

A: I support focusing priority attention on arthritis, considering its economic and social impact on millions of Americans. Arthritis and musculoskeletal diseases are now receiving an appropriately high level of research support within NIH.

The National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDK), the lead institute for arthritis, has taken several steps to strengthen the conduct and support of arthritis-related research. This program has grown more rapidly within the last six years than any other in NIADDK or NIH, as a whole. The preliminary budget for arthritis-related research in FY 1983 is $83.6 million, up by $9.3 million from FY 1982. Since 1976, funds expended for arthritis research have doubled.

With regard to a separate institute for arthritis, I believe that such a reorganization is premature. At the Department's request, the Institute of Medicine of the National Academy of Sciences will conduct a review of the entire NIH organizational structure. The review will begin soon and will be completed in 1984. We oppose creating any new institute prior to completion of this comprehensive review. When the IOM issues its report, we will consider program management issues for NIH in general and the arthritis program in particular.

I alert you, however, to some of our concerns regarding a separate arthritis institute. First, cost estimates to create a new institute approximate $4 million. These costs necessarily would result in a significant drain on funds committed to critical research. Second, our view is that the arthritis and musculoskeletal diseases research programs benefit from their close association with the other disease areas within the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases. Creation of a separate institute may diminish opportunities for fruitful research collaboration.

Senator Pell

Question: Are you committed to maintaining the training aspect of Title V?

Answer: We are committed to maintaining the central focus of the Title V program, that is, to assist low-income older persons in obtaining a measure of economic self-sufficiency.

While our proposal would maintain the current aspects of employment from the current program, we are also considering expanding the flexibility of the program by including an economic development component.

The program would provide seed money grants for the following purposes: (1) to employ older persons in positions which have the potential of moving the older persons into permanent employment and thereby enhancing their opportunities for self-sufficiency; and (2) to make grants to individuals, organizations, or groups of older persons to initiate economic development enterprises, which, after start-up support, will become stable ongoing businesses owned and operated by the older persons.

The intent would be to use resources in a manner which will benefit not only the older persons, but which will contribute to the development of the community at large. We would be happy to discuss this proposal in detail after it is submitted to Congress.

Senator Pell

Question: Why do you think the Administration on Aging is better able to administer this training program?

Answer: The Administration on Aging has a great deal of experience in operating formula grant programs to States under Title III of the Older Americans Act. The Administration's proposal for the employment and economic development program would in effect parallel the structure now in place for operating the existing nutrition and supportive services programs under Title III.

State and Area Agencies on Aging have been involved in administering the existing Title V program in coordination with the eight national organizations. Because of the aging network's familiarity with Title V, we would not anticipate any major difficulties arising from the proposed change.

In addition, each Area Agency on Aging could, if it so elected, enter into arrangements with any of the current national contractors to carry out activities within its planning and services area.

Question: Are you committed to maintaining present funding or increasing funding for Title V?

Answer: We are asking for funding of $277.1 million in FY 1984. This is the same level of funding as this program received in Fiscal years 1981 and 1982, and $4.85 million less than the funding for Fiscal Year 1983.

This is consistent with Administration policy of reducing the growth of Federal expenditures, while at the same time holding funding generally level in those programs that provide direct services.

Senator Bell

Question: Unemployment among older Americans has increased drastically, by over 50%, during this recession, yet the Administration's proposed budget for 1984 calls for a decrease in funding for senior meal sites and home-delivered meals for seniors. With increasing unemployment and increasing need for nutrition and health services by older Americans, how can you justify a cut in funding for senior meals?

Answer: In order to hold the increase in Federal spending as a whole to no more than the rate of inflation, as stated by the President in his State of the Union message, spending for non-entitlement programs must be reduced.

It is projected that in FY 1983 the total number of meals provided under Title III nutrition programs will amount to 190 million. We anticipate that through a number of initiatives which are being taken to increase the productivity rate, the total number of meals provided in FY 1984 can be maintained.

Analysis of the program and financial data reported by the States over the last three years indicates that network organizations have been successful in improving their productivity during a period of level Federal funding by using a variety of management techniques. These include:

- consolidating small, high cost sites with larger, more cost effective sites to reduce overhead expenses;
- improved financial management practices which build on effective constracting, budget planning, and accounting systems; and,
- consolidated food service contracting which permits a number of service providers to contract with a single contractor to take advantage of savings achieved through bulk purchasing.

Q. Do you think that raising the retirement age from 65 to 66 is a good idea?

A. I strongly support the recommendation of the National Commission on Social Security Reform that the long-range deficit be eliminated. This is an important step to help restore public confidence in the Social Security system's ability to meet its commitments to future generations of retirees. I am not, however, committed to any one of the several means by which the remaining long-range deficit might be addressed. Raising the retirement age gradually beginning at some point after the turn of the century is certainly one of the options that must be considered, given the large increases in longevity that have occurred since age 65 was selected as the Social Security retirement age in 1935 and that are projected for the future.

Pell

Q: The Administration FY '84 Medicare proposals would reduce projected expenditures by $1.76 billion. These savings result from increased out-of-pocket costs to beneficiaries and cost shifting to private payors. Do you have any systematic reform plans?

A: The Medicare savings for FY 1984 result primarily from reforms designed to reverse the negative incentives that produce inflation in the health care system. Currently, the costs of health care are essentially hidden from both providers and consumers. The cost-based system now used to reimburse hospitals offers little incentive to control costs. Similarly, consumers feel little pressure to thoughtfully and prudently purchase health care because the costs are covered by health insurance, often provided at little or no expense to them by their employers.

Instead of capping prices and services artifically through regulations, we want to create positive incentives to contain costs. Our incentive reforms call on physicians, hospitals, insurers, consumers, employers and government to work together and share this responsibility. Through initiatives such as our proposed prospective payment to hospitals, restructured cost-sharing for hospital care, catastrophic coverage for the costs of lengthy illness, maintaining the existing level of physician reimbursement for one year and capping the amount of health insurance that can be purchased tax-free, we will promote cost consciousness through the appropriate use of health care resources.

Q.: In states which presently have voluntary prospective systems in place, do you believe the Federal government should allow for flexibility based on local needs and experience?

A.: Our proposal gives the Secretary the authority to continue to develop, carry out, or maintain Medicare experiments and demonstration projects testing state alternative reimbursement approaches. As indicated in a statement in the October 8, 1982 Federal Register, we are interested in competition, capitation, DRG systems and other innovative approaches.

As for current programs approved under our waiver authority, they will each be reviewed at the time they expire, in terms of their effectiveness and compatibility with a national system.

Pell

Q: What is your view of the catastrophic illness coverage plan proposed by the Administration? Specifically, do you think that it overly increases out-of-pocket expenses for beneficiaries?

A: I think it is a good solution to a very troubling problem. Catastrophic illness coverage will eliminate a major fear of the elderly -- that extraordinary hospital expenses will wipe out a life's savings. While in our proposal modest cost-sharing is required for the first 60 days of hospitalization, coverage continues without limit and the beneficiary has no further liability.

The proposed changes in Medicare would make its coverage more fair by using moderate cost-sharing early in a spell of illness rather than imposing it heavily late in a spell of illness when the patient is likely to have little or no control over length of hospital stay.

Q: What is your view of the Administration proposal to tax health benefits received by employees?

A: At present, all employer contributions to employee health benefits are tax-free to the employees. The new plan would allow tax-free treatment up to $175 per month for family coverage, or $70 per month for individual coverage.

Currently, about 30 percent of those with employment based health coverage receive employer contributions above these limits.

While individuals and companies would remain free to purchase as much health coverage as they desire, the new provision would eliminate the bias that now works in favor of high-priced coverage and against comparable higher wages.

The health incentives reform plan seeks to change federal policies that have thwarted incentives for efficiency and thus contributed to high health cost inflation.

Q. There is one issue of importance to my home state of Rhode Island regarding the classification of one of our hospitals as a rural facility. The hospital has been frustrated in its attempts to discuss this classification. I will submit the necessary information to you in writing. I would appreciate it if you would direct the involved officials to contact my staff to discuss the situation.

A. I understand that HCFA officials met with members of your staff recently. They agreed that for FY 1983, HCFA would, for purposes of reimbursement under Medicare, apply the urban wage adjustment to that hospital. Under H.R. 1900, as reported by the Senate-House Conference Committee, the Secretary is required to classify any hospital in New England as being in an urban area if the hospital was located in an urban area under the SMSA system of classification in effect in 1979. I believe that this should resolve the problem.

Senator Metzenbaum

Q. Over the past two years, the Department of Health and Human Services has had a series of controversies over the family planning program. I believe that it might be very productive for you to meet with some representatives of family planning service providers. Would you be willing to sit down with some professionals in this field to at least start a dialogue between government and the service providers?

A. Yes, I would be glad to meet with professionals in the family planning field. In addition, plans are presently underway to establish family planning advisory groups, including Title X service providers, and meetings to provide valuable input and expertise on various pertinent issues for the Department.

Q: In my state of Ohio and, I understand, in all of Region V, family planning agencies have expressed deep concern over the new formula for the distribution of funds. A key factor in evaluating programs and, thus, in distribution of funds is the ability to attract other sources of funds, such as state money. I am sure you are aware of the extreme financial crisis facing my state as well as others in the Midwest due to painfully high unemployment rates. To penalize family planning programs in these states for their inability to obtain other funding just adds to this burden. Would you consider reviewing this formula again with a view to minimizing the importance of this particular factor?

A: The allocation formula for the distribution of Title X funds has been a major concern of family planning agencies. Service providers have indicated that they favor an equitable formula based on need and performance factors. These providers have also asked that we avoid the large fluctuations in the formula that have occurred in the past and that there be more stability in the future. Therefore, to help us arrive at a better formula for allocating Title X funds, the appropriate officials within the Department will be holding a series of meetings in each of the regions in the next several months.

1. As a result of the Social Security Administration's review of disability cases, many severely disabled persons were eliminated from the disability rolls. Yet 67 percent of those who appealed were reinstated by an Administrative Law Judge, but only after the anxiety and pain of waiting over a year without benefits or Medicare coverage and after incurring enormous legal expenses. In response to this, Congress passed a temporary emergency measure in the lame-duck session to continue benefits pending this appeal to an ALJ. I believe that the right of SSDI recipients to receive benefits pending appeal is absolutely essential and should be made permanent. Do you agree?

Yes. The administration supports paying benefits through the first level of appeal that includes the opportunity for an evidentiary hearing. Now, the first opportunity for an evidentiary hearing occurs at the second level of appeal--the ALJ hearing. However, P.L. 97-455 mandates that, by January 1984, the reconsideration process (the first level of appeal) be changed from a file review to a full evidentiary, face-to-face hearing. We therefore support a permanent provision to permit disability benefit payments through reconsideration at the point where a full evidentiary hearing is provided at reconsideration. I would also like to point out that the actual percentage of cases that has been reinstated by ALJs is 61 percent.

2. I understand that the Social Security Administration has a policy of non-acquiescence with certain lower Federal court decisions, that is, they do not abide by Federal district and appeals court decisions with which they disagree. SSA's rationale is that Social Security is a national program and should not, therefore, be bound by anything short of a United States Supreme Court decision. However, at the same time, SSA refuses to appeal unfavorable lower court decisions to the Supreme Court, creating a "catch-22" situation. This makes no sense to me. If a Federal court holds that the Social Security Administration is misinterpreting the law and you disagree with that finding, it would seem that the Department has a responsibility to appeal that decision so that the Supreme Court has the opportunity to rule on the question. Do you agree?

SSA abides by all final judgments of Federal courts with respect to the individuals named in particular suits. However, in the rare case where a lower court's decision is contrary to the Secretary's interpretations of law and regulations, SSA has a longstanding practice of publishing a ruling stating that SSA will not adopt the court's decision as agency policy. This practice, which I understand is also used by other Federal agencies, is necessary to ensure that the agency follows its congressional mandate to administer the Social Security program nationwide in a uniform and consistent manner. On a practical basis, it sometimes is impossible to adopt a court decision as national policy because of conflicting court decisions in different jurisdictions.

Metzenbaum

There are several reasons why SSA does not recommend appeal to the Department of Justice of all lower court decisions that are contrary to the Secretary's interpretations of law and regulations. (The Solicitor General has final authority to determine whether a case should be appealed.) For example, if the same issue has been decided by a number of courts and the weight of the decisions agrees with the Secretary's interpretation, SSA may decide not to recommend appeal of the minority of cases which disagree with the Secretary's interpretation. To appeal all such cases would be administratively expensive, would be an inefficient use of limited Federal legal resources, and would aggravate the already heavy burden of litigation in Federal courts.

If, on the other hand, the weight of the court decisions on a given issue does not agree with the Secretary's decision, SSA generally recommends appeal of one or more of the cases. In this situation, also, it would be inefficient to appeal every unfavorable decision, and SSA selects the case or cases that clearly present the issue to be decided and tries to avoid appealing those cases where consideration of the larger issue could be clouded because the specific facts in the cases are not clear.

Finally, in some situations, the majority of court decisions involving an issue may disagree with the Secretary's interpretation and remedial legislation by the Congress may offer an alternative to resolution through the judicial process. For example, a number of courts have ordered SSA to pay interim benefits before making a final determination of entitlement in cases where the courts believe SSA has taken too long to resolve administrative appeals. Social Security law clearly does not permit SSA to pay these interim benefits, and the administration supported legislation in Congress last year that would have amended the Social Security Act to further clarify that these interim payments are not permitted. However, these decisions are also being appealed.

3. Several Federal courts have recently held that persons who have been found to be permanently disabled by SSA could not later be removed from the rolls without a showing that there was some improvement in their medical condition or that the initial decision to grant benefits was clearly erroneous. This is one of the decisions that SSA refuses to abide by. Last year there were numerous negotiations between Senate staff and SSA staff to work out a legislative proposal incorporating the principle of medical improvement, but none of the proposals were acceptable to SSA. Would you be willing to give further consideration to the possibility of requiring a showing of medical improvement before a recipient could be terminated?

Disability benefits are terminated when a beneficiary does not currently meet the strict definition of disability in the law. While some Federal courts have decided that SSA should show medical improvement, the law does not contain a medical improvement requirement.

A basic problem with a medical improvement standard is that it would create different definitions of disability for initial claims and for continuing disability investigations. This would be unfair to people now applying for benefits who could not receive benefits even though they are in the same condition as some people now on the rolls. Also, having to apply two different definitions of disability would complicate administration of the disability program.

A medical improvement standard could undermine a basic eligibility requirement--that beneficiaries meet the definition of disability in the law. Some conditions once thought disabling may no longer be because of advances in medical science and therapy. In other cases, a beneficiary may no longer be disabled because he or she has received education or training that has improved his or her vocational outlook to the point that the beneficiary can work.

A medical improvement standard would complicate administration because it is difficult or impossible to compare a person's current condition with his or her condition at the time benefits were awarded. The type of evidence used to make a disability determination in the past frequently differs from the type of evidence currently used because of changes in medical technology or changes in the regulations. Consequently, comparison of the severity of a condition in the past with a current condition could involve measures made on two different scales with no means of converting from one scale to the other.

Although there are major difficulties with the concept of a medical improvement standard, we are willing, of course, to continue working with the Congress to address the concerns raised by this issue.

4. I understand that the Department is in the process of taking certain policy guidelines governing the Social Security disability program and publishing these as Secretary's rulings without the benefit of a public notice or comment period. Some of these guidelines are quite controversial and it has been alleged that some are contrary to Federal law. Obviously the State agency personnel who follow these program guidelines are making very different decisions on the disability reviews than the ALJs who are not now bound by such guidelines. Given this controversy, wouldn't it be preferable to publish these guidelines as proposed regulations so that the Department has the benefit of both public and congressional comment?

SSA is now issuing rulings to make sure that all disability decisionmakers--State agencies, ALJs and the Appeals Council--follow the same standards of adjudication. These rulings are in accord with existing law and regulations and do not establish new standards. Each ruling is carefully reviewed by the Office of the General Counsel to assure that it is fully consistent with and not in conflict with existing regulations. The rulings provide background details and a fuller explanation of the standards already published in regulations, which are subject to public comment. Since these adjudicative guides do not set new standards, we do not think it is appropriate to publish them as proposed regulations.

Senator Dodd

Question: With respect to programs serving our younger citizens, I understand the Office of Human Development Services has recently consolidated research funds from various pieces of authorizing legislation. Thus, research funds for the Head Start, Runaway Youth, Adoption, Developmental Disabilities, and Native American Programs are all lumped together. We do not know how OHDS can apportion these funds according to Congressional mandate if they are consolidated. Will you carry our concerns to OHDS that research money be spent on the specific programs it was intended for?

Answer: There was no consolidation of research funds, and Congressional mandates, as reflected in authorizing and appropriations laws, were carefully observed.

What OHDS carried out was a coordinated discretionary funding process, involving 9 of the 19 separate discretionary programs in HDS. The mechanism for coordinating these funds was a joint program announcement in which some of each program's priorities were included, in particular those that were also relevant to the other programs. This increases the impact for the money spent, where issues are related to more than one specific social service program, and avoids duplication in project spending. In addition, issues specific to one program, such as adoption or child abuse, were also included in the process.

All funding decisions are still made by the appropriate program heads, and the requirements imposed by the enabling legislation of each of the programs were fully observed.

Question: (In the Administration's budget proposal) Aging research and training funds are to drop from $22.2 to $5 million. Given that some of our most innovative programs have grown out of R&D projects (witness elderly nutrition) what do you propose to do about these cuts?

Answer: The proposed reduction is consistent with the policy to reduce activities which do not directly provide services. The proposed funding level will allow the Administration on Aging to continue to provide assistance to State and Area Agencies on Aging through projects directed to service system development and management.

The mission of the Administration on Aging is carried out mainly through Title III and Title VI programs. The Title IV program support efforts which add to knowledge needed to improve program effectiveness and efficiency. The request will allow continued modest support for these efforts.

Finally, we recognize that there currently exists an accumulated base of research and demonstration knowledge that has not found its way into the aging network. We will place priority on the dissemination and utilization of the knowledge that has not found its way into the aging network. We will place priority on the dissemination and utilization of the knowledge base rather than the development of additional projects which may be duplicative.

Senator Dodd

Question: What do you mean by economic development?

Answer: The term "economic development opportunities" refers to a new concept which the Administration is considering as part of the proposal on the Title V Program.

The proposed program would continue to provide employment opportunities for older workers, as is currently the case under Title V, which would be repealed. However, the new program would broaden the types of activities which could be supported in the interest of promoting the economic self-sufficiency of low-income older persons.

Specifically, area agencies on aging would be authorized to make grants to groups of older individuals or organizations for the purpose of initiating enterprises which are designed to become stable ongoing businesses owned and operated by, and providing employment for, individuals age 55 or older.

The grants would be in the form of "seed money" to help older people initiate an enterprise. Grants would be permitted for any type of enterprise sponsored by older persons themselves which the area agency on aging determined would (1) foster the economic self-sufficiency of the older persons sponsoring the project; (2) contribute to the improvement of the community at large; and (3) become self-sustaining within a period of three years or less.

The economic development opportunities approach is consistent with the overall purposes of the Administration to foster private enterprise and to reduce long-term dependence on public support of persons who, by the combination of their own initiative and the stimulus of initial Federal support, can achieve economic independence.

Senator Dodd

Question: How do you plan to ensure that Title V remains intact within this new economic development initiative?

Answer: Our proposal on the Title V program, which will be sent to the Congress in the near future, will change the program in some respects. However, the basic goal of the program will not change.

Presently, Title V is directed at assisting low income persons to obtain a measure of economic self-sufficiency. This focus will be retained.

We would like to have this program administered through the State and area agency aging network, and we want to expand the program to include economic development activities. The program would still, however, include the same kinds of of employment programs now assisted under the Title V program. The details of this proposal have not been finalized. We will be happy to respond in more detail when we send the bill to Congress.

Q: FY 83 funding for ASPE is $14.7 million. OMB requested only $2 million for FY 84 but that figure was upped to $11 million. How do you expect to protect ASPE from any future zeroing-out requests? How will you use ASPE to develop your own policy initiatives for HHS?

A: First, let me address the part of the question concerning the staff of the ASPE. The OMB reduction both as originally proposed ($7 million, not $2 million) and as finally requested in the President's budget applied only to Policy Research grants and contracts, not to the ASPE core staff who advise the Secretary on policy questions. The President's budget for 1984 maintains ASPE staff at the 1983 level of 126 positions. ASPE staff have been, and will continue to be, vital in developing HHS policy, both for continuing functions such as legislative and regulatory development and for major initiatives, such as the President's Health Incentives Reform Initiative and the design of the health and human services block grants. I expect to continue to use ASPE for these purposes, as have all HHS Secretaries since the late 1960s, when the Office was formed.

Second, concerning protection of funding for Policy Research conducted by ASPE, this research has, and I am sure will continue, to provide findings and data important to the development of effective human service programs and policies. Because of this and the Policy Research program's contribution to major initiatives, I doubt that it will be "zeroed out."

Q: A recent report from the Institute of Medicine revealed that as many as 50% of deaths attributed to the ten leading causes of death in this country are influenced by behavioral habits and life-style. Moreover, the report pointed out that the effect of behavior on the burden of illness is reflected in the fact that alcohol abuse, cigarette smoking and obesity are present disproportionately among patients with high hospital costs. At present, the Department is spending money studying disease processes but not behavioral habits which could be altered to prevent such diseases. How do you intend to implement the recommendations of the Institute of Medicine?

A: The Department's activities are directed on many of the areas specified as particularly important in the National Academy of Sciences study. Behavior does play a prominent role in many of the leading causes of death and, recognizing this, the Department developed a health promotion program directly targeted toward enhancing individual behavior changes which could improve the prospects for good health. This program, which I intend to carry forward, is designed to marshall the resources of the Department's programs to promote better health habits among Americans. In addition, this program is designed to increase our efforts on prevention-related research, particularly at the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. I believe that the current emphasis of the Department regarding the total range of prevention programs will provide fertile ground for implementing the National Academy of Sciences recommendations.

The **Chairman**. With that, we will recess the committee and we will go to your nomination on the floor. [Applause.]

[Whereupon, at 4:55 p.m., the hearing adjourned.]

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